FY 2006 Mental Health Block Grant Implementation Report

Submitted by
Richard E. Kellogg, Director
Mental Health Division
Health and Recovery Services Administration
Department of Social and Health Services
DUNS # 12-734-7115
Olympia, Washington
November 30, 2006

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Mental Health Division
P.O. Box 45320, Olympia, Washington 98504

November 22, 2006

LouEllen M. Rice, Grants Management Officer
Division of Grants Management
OPS, SAMHSA
One Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Rice:

Enclosed is Washington State's Community Mental Health Services Block Grant Implementation Report for fiscal year 2006. This plan meets the requirements of Public Law 102-231, has been created with and approved by the Mental Health Planning and Advisory Council, and contains all the requisite data necessary to ensure its eligibility for consideration.

As you may know, Washington submitted its 2007 MHBG Plan via the new Web B-GAS system. In doing so, we also significantly changed our Plan and Performance Indicators from those contained in the 2006 MHBG Plan. Since this Implementation Report correlates directly with the 2006 MHBG Plan, it is being submitted in hard copy for consistency sake and ease in review. It is our last hard copy document related to MHBG as we transition fully to the electronic reporting system created by SAMSHSA.

Thank you for your time as well as your interest in the public mental health services delivered in Washington State. If you have any questions, please contact Amy Besel, the designated State Planner. She may be reached at BeselAJ@DSHS.wa.gov or 360-902-0202.

Sincerely,

Richard E. Kellogg, Director
Mental Health Division

Enclosure
cc: Amy Besel, State Planner
Joann Freimund, MHPAC Chair

FACE SHEET
FISCAL YEARS COVERED BY THE IMPLEMENTAION REPORT:

__FY 2005-2007 _**X**_ FY 2006 _FY 2007

STATE NAME: Washington State

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Social and Health Service, DUNS # 12-734-7115

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia ZIP CODE: 98504-5320

TELEPHONE: 360-902-0807 FAX: 360-902-0809

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Richard E; Kellogg TITLE: Director

AGENCY: Department of Social and Health Division

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia ZIP CODE: 98504-5320

TELEPHONE: (360) 902-0790 FAX: (360) 902-0809

III. STATE FISCAL YEAR

FROM: July 1, 2005 TO: June 30, 2006

IV. PERSON TO CONTACT WITH ANY QUESTIONS REGARDING THE APPLICATION

NAME: Amy Besel TITLE: Mental Health Program Administrator

AGENCY: Department of Social and Health Services

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia ZIP CODE: 98504-5320

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TABLE OF CONTENTS

2006 Community Mental Health Services Block Grant Implementation Report

Part A: Executive Summary

The Mental Health Division (MHD) of the State of Washington herein submits its Implementation Report for the utilization of Community Mental Health Services Block Grant funding for FFY 2006. With the help of this valuable resource, we are honored to serve both the people in our state who carry psychiatric disabilities and the people around them who love and care about them. This document is intended to capture the successes of this past federal fiscal year as well as identify opportunities for continued growth. Further, it is expected to serve as tangible evidence of both the progress toward and the commitment to the ***Transformation*** of Washington State's public mental health system; this being driven by the people whose well-being and quality of life are deeply affected by it.

The following Implementation Report meets all of the requirements of the grant, has been reviewed by community stakeholders, is supported by the state Mental Health Planning and Advisory Council (MHPAC), and is consistent with federal guidelines aimed at achieving the following goals:

- Increasing access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports;
- Ensuring the participation of consumers and their families in planning and evaluation of state systems;
- Improving access for underserved populations, including homeless people and rural populations;
- Expanding the promotion of recovery and community integration of people with psychiatric disabilities; and
- Delivering accountability through uniform reporting on access, quality, and the outcome of services.

In tandem with the federal guidelines listed above, this document encompasses Washington State's commitment to bring to fruition the fundamental goals outlined in the July 2003 Final Report of the President's New Freedom Commission on Mental Health entitled, ***"Achieving the Promise: Transforming Mental Health Care in America."***

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.

- Excellent mental health care is delivered and research is accelerated.
- Technology is used to access mental health care and information.

It should be further noted that these goals are fully embraced by the Mental Health Division, the leadership of Washington State, the Mental Health Planning and Advisory Council, and the consumers, families and advocates involved in Washington's public mental health system. Accordingly, the New Freedom goals have been integrated with the goals of the Mental Health Planning and Advisory Council and addressed within the Mental Health Division's Strategic Plan which serves as the platform for Washington's aspiration to realize ***Transformation***.

In 2005, the stage was set for change in Washington State in terms of the energy, discussion, and challenges that transpired related to our public mental health system through the following activities:

- The creation of a legislatively mandated Mental Health Task Force (MHTF) charged with assessment of the mental health system and challenged to determine recommendations for improvements;

- The significant threat of system implosion secondary to the projected financial losses related to the combination of the discontinuation of the use of Medicaid managed care savings (which had been relied upon to support individuals and services not otherwise eligible for Medicaid) and the existing Institution for Mental Diseases (IMD) Exclusion; and

- The passage of legislation that paved the way for dramatic and far-reaching revisions in the public mental health system including mental health insurance parity, approval of nearly $80 million dollars in state funding to mitigate losses related to the change in the use of Medicaid savings and the IMD exclusion, and a mandatory procurement process for the delivery of managed care services.

Further moving our service delivery system forward has been the structural changes initiated by the new Secretary of the Department of Social and Health Services (DSHS), Robin Arnold-Williams. Secretary Arnold-Williams, who came to Washington after serving under Mike Leavitt, then Governor of Utah and now Secretary of Health and Human Services, has since combined the Division of Alcohol and Substance Abuse, the Mental Health Division, and the Medical Assistance Administration under the leadership of tenured Assistant Secretary, Doug Porter in what is now called the Health and Recovery Services Administration. This re-alignment is intended to improve collaboration and resource management, with the result being improved outcomes for the residents of our state.

Washington State is proud to be one of the seven (7) recipients of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation System Improvement Grant (referred to as the Transformation Grant). The evolution of ***Transformation*** remains the driving force in Washington, with all efforts focused on the

uncharted path of this journey. Under the guidance of Governor Christine O. Gregoire, Washington is demonstrating a firm commitment to all residents, both in policy and in practice, by dedicating the necessary resources, expertise, and visionary leadership toward a future where ***Transformation*** of the public mental health system becomes reality.

The Governor and the Secretary of the Department of Social and Health services (DSHS) led the initiative to solicit input from stakeholders, system partners and community members who were invited to inform policy makers through both the internet and participation in a statewide forum. The forum allowed those involved to provide input, ask questions, and collaborate in the development of an initial plan outline for the grant application. An extensive survey was also disseminated and posted on the internet which provided an additional opportunity for detailed contributions to the planning effort. Finally, the Governor completed appointment of a Transformation Work Group (TWG) comprised of consumers, cross system leaders, family members, community members, mental health providers and other interested parties. The TWG has since created task groups which have traversed even further into territory of "What would a transformed system look like", culminating in the truly collaborative development of the state's first stage Comprehensive Community Mental Health Plan or ***Transformation*** Plan, also submitted to SAMHSA in the fall of this year. The web-site for the Transformation Grant is: http://mhtransformation.wa.gov/.

Momentum for change has marched ahead in 2006 through the considerable direction and support of the state legislature:

- Involvement of the MHTF has continued through oversight of the procurement process; providing direction to MHD in setting the bar for excellence and ensuring RSNs have the opportunity to rise to the requisite level needed to qualify as an RSN.

- Completion of a legislatively mandated procurement process for the fourteen (14) Regional Support Networks (RSNs) which was two fold: Request for Qualifications (RFQ) and Request for Proposals (RFP). The results were as follows:

    - RFQ - only eight (8) of the original RSNs qualified.
    - RFP - Five (5) of the unqualified RSNs re-submitted and passed. One (1) RSN did not re-submit. However, another RSN that passed the RFQ submitted a proposal to take over the remaining unqualified RSN and passed.
    - As of September 1, 2006, Washington now has thirteen (13) RSNs, all of which are fully qualified to deliver excellent mental health services.

- Funding requested of the legislature by MHD Director, Richard E. Kellogg, who arrived in January 2006, was awarded to address critical concerns regarding insufficient inpatient capacity. The solution attacks the issue from two fronts: the

short-term need for more inpatient beds at the state hospital and the long-term need for enhanced community supports through development of eight (8) teams which will deliver the evidence based practice of Program for Assertive Community Treatment (PACT). As PACT teams are made operational, hospital wards will be closed.

Also with considerable legislative support, MHD leadership is undertaking four (4) additional measures that, when combined with the PACT teams above, constitute MHD's five (5) ***System Transformation Initiatives*** (STI's). Each STI has a task force consisting of a wide variety of stakeholders including: consumers, advocates, and family members, representatives from MHPAC, RSNs, and other allied partners, as well as law enforcement and sister social service agencies. Recommendations will be drafted and brought forward by these groups and are intended to accomplish the following:

- **PACT Teams**: Facilitate implementation of 8 Program of Assertive Community Treatment Teams throughout the State, increasing psychological, vocational, and residential stability of persons with intensive psychiatric disabilities while decreasing their involvement with state and community hospitals, emergency rooms, crisis response services, and correctional institutions

- **Housing Plan**: Develop a statewide mental health housing plan which is supportive of Recovery and prioritizes independent housing for consumers.

- **Benefits Package:** Review the public mental health benefits package to ensure services are recovery oriented and maximize effectiveness and efficiency of resources.

- **ITA Study:** Conduct a study of Washington State Involuntary Treatment Act statutes and develop options for legislative and administrative improvements.

- **Utilization Review:** Develop standardized platform for UR of individuals served in state and community inpatient settings.

With these aims in mind, the Mental Health Division strives to combine the best practice standards of the private managed care industry with the core values of the publicly funded mental health system to create a service delivery model that promotes high quality and cost effective services which are consumer driven and focused on ***Recovery*** and ***Resiliency***.

We are continually searching for improvements to our system; making certain that access to services consistently meets individual needs, that provision of community linkages are continually strengthened, and that the integration of other publicly funded services and

natural supports are unfailingly pursued. The intended outcome is a delivery of care system that is fiscally sound, consumer driven, recovery oriented, and highly responsive to the needs of our citizens, recognizing that true ***Transformation*** is not a destination, but rather a process of continuous change and quality improvement.

Part D: Implementation Report Narrative

I. Areas of Needed Improvement

The ***System Transformation Initiatives*** (STIs) described in the Executive Summary were created in direct response to the recognition of several important areas of needed improvement and are intended to address issues raised by legislatively driven Executive Mental Health Task Force, the Transformation Work Group, public comments on the state Plan and the advisement of the Mental Health Planning and Advisory Council.

While much more work needs to be done to strengthen our service delivery system, it is believed that the STIs are a great start. Through the critical feedback of others and the willingness of the system to change, Washington State also recognizes the following issues as important to address.

Criterion 1: Comprehensive Community Mental Health Plan

As with most public mental health systems, Washington State struggles with having limited resources to meet the basic needs of its consumers. Recognizing this, MHD seeks creative ways to encourage the RSN's to address the call for recovery, not just maintenance, which unfortunately can be perceived as a message to "do more with less". As we move forward to implement the changes intended to promote greater consistency and more equitable access to high quality services, remaining aware of potential shortcomings within the system must be a priority as well.

With everyone involved from consumers and family members to the Governor, Washington has a reasonable grasp on where, in our continuum of care, chasms exist. While we are currently experiencing an unprecedented focus on the mental health system and the services provided therein, special attention will be devoted to the following fundamental items as we look to the future:

- Increased attention to residential supports, housing resources, and affordable housing to reduce homelessness and substandard housing for individuals with mental illness;
- Greater consideration to the process by which individuals who are eligible for Medicaid services can become recipients of such, allowing for increased access to not only mental health benefits, but to dental and medical services as well;
- Enhanced supports to help those consumers who can return to work or go to school do so, as evidence shows that feeling productive and having purpose in one's life is critical to not only decreasing one's symptoms, but to making meaningful recovery a reality;

- Focused efforts to increase early intervention and prevention, cultural competency, and community education, thereby decreasing discrimination, stigmatization and the criminalization of persons with psychiatric disabilities; and
- Expansive involvement of consumers in directing the mental health service delivery system in Washington, thereby providing them with what they say they need, when they need it, ultimately empowering them to take responsibility for themselves and realize their right to the pursuit of happiness.

Data Used to Identify Unmet Services and Critical Gaps:

All of the issues above have come to light through the data collection and interpretation derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community organizations, and consumer/ family voice.

Plan to Address Unmet Services and Critical Gaps:

As articulated earlier, the MHPAC has worked diligently with MHD over the past year to revise our strategic plan, which is briefly outlined below.

The new strategic plan encompasses the issues highlighted above, providing the structure and foundation for our system's transformation based upon the New Freedom Commission's goals for transforming mental health care in America.

In an effort to encourage accountability and ensure the strategic plan remains a living document, the MHPAC has absorbed the annual task of reviewing the document against available data and then providing feedback to MHD. It is hoped that through this process, the Strategic Plan will be utilized as a highly valuable roadmap to system transformation.

MISSION STATEMENT:

"The Mental Health Division administers a public mental health system that promotes recovery and safety."

GUIDING PRINCIPLES/CORE VALUES

1. Promote the understanding that mental health is essential for overall health for all Washington residents.
2. Encourage consumers and families to drive the mental health care system, and be

involved in program planning and their own recovery and resiliency process;
3. Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
4. Establish early mental health screening, assessment, and referral to services as common practice;
5. Utilize data to drive decisions to continuously improve health care services and accelerate research;
6. Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

***MHD's Future Vision for Adults*:**

It is the Mental Health Division's vision, held with clear determination, to transform mental health services in the State of Washington, enabling the promotion of real choices for real recovery. In accordance with the recommended changes outlined in the July 2003 Final Report of the President's New Freedom Commission on Mental Health entitled: "Achieving the Promise: Transforming Mental Health Care in America", coupled with the collective use of all available financial and human resources, MHD hopes to provide our citizens with the highest quality of mental health services available; services that are consumer driven, evidence based, and outcome measured.

Criterion 2: Mental Health System Data Epidemiology

Strengths and Weaknesses:

Like other states, Washington continues to struggle with ways in which data collection and utilization may be increased. Despite this, MHD has been successful in increasing the use of data for determining funding allocations, policy direction, and areas for future trainings. Hampering MHD's efforts in this area is a lack of adequate funding for data and research development, including programmatic and staffing shortages at MHD.

Regardless, MHD has made considerable progress in the system's ability to collect and use data that demonstrates the incidence and prevalence of serious mental illness (SMI) in adults and serious emotional disturbance (SED) in children. This is then followed by an increase in ability to turn that data into quantitative targets for system improvement. Some of the achievements and strengths with technology include:

- Maintenance of the MHD website with information on mental health treatment resources;
- Preparation by MHD of an annual Performance Indicator report, which is widely distributed to service providers, consumers, and family advocates. This is also shared with the MHPAC, allowing for well informed input by the Council and consequently serving as the driver for many MHD policy directions, proposed decision packages, and trainings.

- Creation by MHD of a web-based consumer outcome measurement system that provides real-time feedback to clinicians and consumers. These measures are also rolled up to both the agency and state levels to produce statewide indicator reports.
- Maintenance of a detailed data dictionary which is regularly updated by MHD.
- Participation in monthly meetings of a workgroup called the Information Systems Data Evaluation Committee, with members from MHD and RSNs, whose task is to review, evaluate, and recommend changes in the information system, including updates to the Data Dictionary.
- Collection and use of data derived from other sources such as the state hospitals and other state agencies such as the Division of Medical Assistance, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, and the Department of Corrections. This data is integrated and available.
- Development of the ability to store data in a data warehouse for further analysis, research, and integration with other data sets.
- Completion of the first independent audit and report by an External Quality Review Organization (EQRO) as required under the BBA regulations for Medicaid Managed Care which includes an Information Systems Capability Assessment (ISCA) that noted no significant findings and further reported that the State system "was found to be stable and well run".

As indicated in our most recent Mental Illness Prevalence study, completed in 2000, the total number of persons living with SMI/SED in our state is estimated to be 295,844, compared to the 1998 estimation of 157,969. Through combining the estimated number of adults with SMI living below the federal poverty level with the estimated number of children with SED living below the federal poverty level, the total number of persons likely to be dependent upon publicly supported mental health services is estimated at 148,732. These numbers, along with the estimates of Medicaid enrollees per RSN, are useful in determining funding allocations for service provisions.

***Unmet Services and Critical Gaps*:**

While the use of the numbers indicated above is helpful in guiding policy and funding distribution, methodologies for the collection of data is in need of improvement. Some areas targeted for improvements include:

- Incompatible data interface systems between some RSNs and MHD;
- Inconsistent reporting by some RSNs on Performance Indicators; and
- Duplication of data collection efforts between state agencies.

Data Used to Identify Unmet Services and Critical Gaps:

All of the issues above have been identified through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as through the subjective input of MHD staff, the

MHPAC, providers, and multiple other community organizations, and consumer/ family voice.

Plans to Address Unmet Services and Critical Gaps:

As indicated in the MHD Strategic Plan, MHD will continue with efforts to increase the use of technology and data in determining the future direction of public mental health services and system design in Washington. In addition, MHD is actively participating in several collaborative efforts with other DSHS Divisions to improve the process for acquisition of data to be used in future decisions.

MHD's Future Vision for Data Collection and Application:

Through the Medicaid Management Information System (MMIS), the use of the Data Infrastructure Grant (DIG), and the Medicaid Infrastructure Grant (MIG), the Mental Health Division intends to increase its ability to collect, analyze, and apply meaningful data for the development of future programs and policies for all the recipients of public mental health in Washington State. In accordance with goals articulated in the President's New Freedom Report's recommendations, MHD anticipates a steady increase in the use of data and research to drive the course of service provisions which will continue to lead to measurable and positive outcomes for our consumers.

Criterion 3: Children's System of Care

Strengths and Weaknesses:

In 2002, the Department of Social and Health Services formed a workgroup known as, "The Select Committee on Adolescents in Need of Long Term Placement' ("the Committee"), to examine the continuum of care and the sufficiency of services and housing options for youth with the most complex needs. The Committee has published a report that details the current status of services available for these children and makes strong recommendations for sweeping systems change, including adoption of Evidence Based Practices.

A DSHS Children's Mental Health Services Workgroup was convened in December 2003 by the DSHS Assistant Secretaries for the Children's Administration, the Juvenile Rehabilitation Administration, and the Health and Rehabilitative Services Administration, of which the MHD was a division. The Workgroup had thirty members, ten connected with each Administration, including field staff, providers, parents, foster parents, researchers, advisory board members, advocates, DSHS partners and other state agencies, meeting bimonthly through June. A report was presented to the three Assistant Secretaries at the end of July 2004 with recommendations for the improvement of mental health services and how they are delivered by DSHS. A SAMHSA System Improvement Grant was submitted to assist in the implementation of these reform efforts, but was not awarded.

As a result of this work group, and under the direction of the three DSHS assistant secretaries, the Children's Mental Health Initiative was born. As described above, this collaborative effort between the Mental Health Division, the Juvenile Rehabilitation Administration and the Children's Administration was formed to decrease duplication and increase resource management in an effort to provide more comprehensive services to children with SED and multi-system involvement.

One recent accomplishment of this group was the delivery of a report in February 2005 to the three DSHS secretaries, providing valuable research on evidenced based practices (EBPs) for children. In turn, five EBPs have been selected for broad implementation throughout all three systems. They include:

- Multi-dimensional Treatment Foster Care (MTFC);
- Functional Family Therapy (FFT);
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
- Family Integrated Therapy (FIT); and
- Multi-systemic Therapy (MST).

Implementation and delivery of services based on these EBPs are expected to generate treatment outcomes for children, youth and families which will hopefully result in placement stability, improved educational achievements, reduced out of home placements, reduced use of restrictive treatment options and overall improved quality of life and enhanced resiliency. The initiative will target implementation efforts by focusing on workforce development. By supporting specialized training and certification for clinicians, significant work force enhancement can be achieved without disruption to usual funding levels and service priorities. A comprehensive implementation plan has been developed for each EBP with anticipated completion by the end of the biennium.

Another strength of Washington's mental health system for children is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The goal of this endeavor is the identification of promising programs where public schools and public mental health providers may collaborate effectively. A report was subsequently submitted to the legislature in June of last year identifying 25 exemplary programs. Interviews and further information gathering took place last fall. Information about the promising practices identified will be disseminated through the public schools and public mental health systems within the coming months.

Unmet Services and Critical Gaps

While considerable progress continues to be made in many parts of our system, the following targets will require more work to be done to coordinate care across Washington's multi-service delivery system for children:

- Decreased utilization of inpatient care and juvenile justice system;
- Increased family involvement and empowerment;
- Increased community education; and

- Increased utilization of evidence based practices.

Through all of these efforts, the goal of MHD is to ensure that children with SED are treated, nurtured, and strengthened by the services that are provided to them so that they may know stability at home and school, enjoy better health and overall functioning, and ultimately come to realize their dreams, and those of their families', for a future rich in resiliency.

Data Used to Identify Unmet Services and Critical Gaps:

As indicated above, all of these issues have been identified through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, other state agencies serving children, as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community, consumer, and family voice.

Plan to Address Unmet Services and Critical Gaps:

MHD anticipates continued and unfailing dedication in the provision of mental health services, across all service arrays, to those children and their families/supports who struggle with SED while residing in our state.

***MHD's Future Vision for Children's Services*:**

Children *are* our future, and as such, they have an inherent right to experience an environment wherein everyone works collaboratively to ensure their well-being and their development as healthy and happy individuals occurs as it should. The Mental Health Division is committed to the philosophy that everyone deserves a life in the community worth living. Accordingly, the Division goal is to see that children with SED are wholly supported, with all available resources, to become contributing members of society, where they can live, learn, and grow to their fullest potential.

Criterion 4: Targeted Services to Rural and Homeless Populations:

Strengths and Weaknesses:

Through utilization of funds received from Projects for Assistance in Transition from Homelessness (PATH), the Mental Health Division has made considerable in-roads to improving outreach, access, and outcomes for homeless individuals with mental illness.

In support of PATH, MHD used block grant funding aid in the production of two facilitated planning sessions for two regional support networks that were interested in improving their ability to serve homeless people. The RSNs worked collaboratively, enlisting the involvement of mental health providers, social service agencies, police

officials, and other allied providers to attend a joint planning. A facilitator from a well known state housing organization assisted participants to accomplish the following:

- Review current capacity to serve homeless individuals with mental illness;
- Project additional capacity to be attained; and
- Consider strategies to close the gap.

The facilitator provided pre-meeting support and a written report, which included options and recommendations for obtaining additional housing and other needed services. Previous RSNs that have received this technical assistance have become PATH providers or have acquired significant additional housing stock and have put supportive services in place for homeless individuals with mental illness.

Another resource for PATH workers came through a conference which MHD co-sponsored with the Coalition for the Homeless. This was a highly successful event, providing resources, education and encouragement to this dedicated workforce.

MHD has also supported a two-day training session held for providers and allied partners who serve homeless, mentally ill people. The training focused on expediting access to SSI and SSDI benefits. National trainers, sponsored by CMHS, provided two single-day trainings, one focused on direct service providers and the other focused on managers and administrators at a systems level. Participants both days included representatives from the mental health and substance abuse service delivery systems, administrators from the corrections system, staff from the state hospitals and the Taking Health Care Home project, staff from state and federal benefits offices, as well as PATH providers. The positive outcomes of this training will be realized for years to come.

In addition to the services supported through PATH, MHD continues to both provide technical assistance to and facilitates planning sessions with Regional Support Networks, community mental health agencies, local housing, and other service providers in an effort to improve community outreach and decrease homelessness for individuals with mental illness. The intensive planning involves an assessment of the current levels of housing and support services for individuals who are struggling with homelessness, mental illness, and substance abuse. Local participants then determine targets for improvement. Finally, the technical assistance provider assists in identifying viable strategies to meet these targets.

An anticipated result of this technical assistance is the increased collaboration among RSNs and providers with housing and other allied providers. Other outcomes of this training, in addition to a local plan to promote development of safe and affordable housing for citizens with mental illness and homeless individuals, is an overall increase in supportive and ancillary resources for these individuals, which in turn promotes greater housing stability.

One agency supported through MHBG funding that has demonstrated success in outreach and engagement of homeless individuals with mental illness is the Homeless Outreach

Team, which is located in Eastern Washington in one of the state's larger cities, Spokane. This program was the first of four (4) programs assessed this year as part of Washington State's MHBG Independent Peer Review graciously conducted by two members of Idaho's Mental Health Planning and Advisory Council.

This review was conducted in compliance with the MHBG "Funding Agreement", which gives assurances that Washington State will comply with the following section of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1943:

(a) The State will:

(1)(A) for **the fiscal year for which the grant involved is provided**, provide for **independent peer review** to assess the **quality, appropriateness, and efficacy of treatment services** provided in the State to individuals under the program involved; and

(B) Ensure that, in the conduct of such peer review, **not fewer than 5 percent** of the entities providing services in the State under such program are reviewed.

MHD is proud to report that the work of Homeless Outreach Team scored high marks with the Reviewers for the quality, appropriateness, and efficacy of the treatment services they provide. Further, it is hoped that expansion of such quality programs may be promoted in meeting the needs of this target population through the sharing of information that comes from this Peer Review process.

Although this is just one program in one city, the problem of homelessness among those with psychiatric disabilities exists throughout the state. The Division supports the diminishment of homelessness into extinction. The Homeless Outreach team is one

In regard population distribution as it related to rural services, Washington is somewhat unique. 80 percent of Washington's residents live on the Western half of the state, with the remaining 20 percent residing in the Eastern half. The latter is much more rural, possessing vast areas of farmland and desert. Despite this population density disparity, Western Washington also has many rural areas. In reality, the challenge of providing services to our rural residents is actually a state-wide issue.

Living outside of urban areas can prove very challenging when it comes to accessing treatment, with the barriers being not only such obvious needs as transportation and treatment availability, but also more discrete issues such as increased isolation and a culture of intense privacy.

Some of the ways in which MHD has addressed the need for rural outreach has been through supporting training activities on the specialized needs of consumers in these less populated areas. Additionally, RSN's have been required to ensure rural services are provided to a minimum of 25,000 individuals.

For individuals with mental disabilities who are homeless and for those who reside in rural areas, the frequent common denominators are often a lack of both personal support

and quick access to services. While Washington continues to make strides in meeting the needs of these individuals, there remains an immense potential and articulated desire for improvement.

Unmet Services and Critical Gaps:

Washington has made significant progress in providing services to homeless and rural consumers. Areas for future focus include:

- Increased education and training related to the special needs of these two populations and improved methods of engagement in treatment;
- Increased efforts to train providers on how to better assist these individuals in accessing the services for which they are eligible, such as Medicaid and Social Security Disability; and;
- Increased demands for measurable outcomes that demonstrate consistency across population densities.

Data Used to Identify Unmet Services and Critical Gaps:

All of the issues above have been identified through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, homeless counts as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community, consumer, and family voice.

Plan to Address Unmet Services and Critical Gaps:

As referenced in our Strategic Plan, MHD anticipates continued support of programs that have a proven, measurable success rate in engaging underserved populations. We anticipate ongoing use of PATH funds and other resources to train and support providers in effective means of engagement and resource acquisition for homeless persons struggling with severe mental illness and addiction. These efforts are expected to lead to an increase in accessible services across all life domains.

MHD's Vision for Future Services to Rural and Homeless Individuals:

The problems of homelessness and rural isolation are a national concern; certainly not limited to Washington State. However, Washington's MHD hopes to make a significant impact on the provision of services to these populations on a personal, local, regional, and state level as every resident in our state matters. Washington envisions a future wherein everyone who needs public mental health services is counted, engaged, and supported, rather than unseen, given up upon, or just plain "out of luck" because they live one place instead of another.

A key solution in the homelessness issue is the creation of safe and affordable housing.

Another is community education, both in terms of stigma reduction as well as in serving in a gate-keeping function. MHD's ***System Transformation Initiative*** related to development of a housing plan (discussed in the Executive Summary) is expected to unlock doors, both figuratively and literally.

Criterion 5: Management Systems

Strengths and Weaknesses:

Approximately 35 people are employed within the Mental Health Division headquarters. It is from the Division headquarters that the following activities originate, the depth and breadth of which serve as both our strengths and our weaknesses:

- Coordination of state mental health policy and advocacy for a system that promotes prevention, hope, recovery, and culturally competent care;
- Accountability to the legislature for the public mental health system, which includes responsibility for licensure and certification processes, quality management, and the setting of policy and statute;
- Oversight of two primary service contracts: Medicaid and non-Medicaid (or "state-only").
- Management of two adult state psychiatric hospitals and one child psychiatric hospital (which collectively have approximately 2,7000 employees);
- Collaboration with other state agencies for the integration of consumer services across the entire social and health system;
- Reception and incorporation of consumer, family, and advocate voice in MHD business; and,
- Maintenance of a multitude of other administrative functions too numerous to outline.

Unmet Services and Critical Gaps:

Staffing levels and the structure of the Mental Health Division have been in flux secondary to several mitigating factors:

- Under the recommendation of the Mental Health Task Force, MHD established an independent contract to determine MHD readiness for procurement as well as to assess general functions and ways in which work should be delegated. The results of that report, called the Mercer Study, indicate a marked need for increased staffing at the Division headquarters to accomplish the work at hand. Additionally, the study recommended several changes within the organizational structure. MHD Management are currently analyzing potential changes to the organization structure, giving greater than before focus to contract compliance, monitoring, licensing, and coordination with the legislature and the community to bring about more transformative measures.

- MHD has also undergone a larger administrative realignment under the direction

of Secretary Robin Arnold-Williams. The expectation of streamlining DSHS performance and increasing accessibility to services for our state's residents is clear. As such, MHD has been realigned with two former sister agencies: the Medical Assistance Administration (MAA) and the Division of Alcohol and Substance Abuse (DASA) to form a new administration called the Health and Recovery Services Administration (HRSA). Through the realignment, the concept of shared services was introduced with all three Divisions now jointly utilizing the skills and knowledge of staff performing in the fields of Information Technology and Finance.

- In an effort to reduce expenditures, Governor Gregoire mandated a reduction in force (RIF) of 1000 middle-management employees across all state agencies by the end of June 2007. The Department of Social and Health Services, of which MHD is a division, is expected to decrease its staffing by 330. MHD's assigned reduction requirement, which includes the two state hospitals, is 19 positions. DSHS Secretary, Robin Arnold-Williams, has been sympathetic to both the recommendations of the Mercer Study and the Governor's mandate and has used her authority to shift staffing resources where necessary, which has resulted in the development of seven (7) new staff positions at MHD headquarters. While this is a remarkable addition, it unfortunately does not meet the need of MHD for both completion of existing work and the promotion of change. Accordingly, MHD continues to advocate for even more staff to meet these challenges.

Plan to Address Concerns for Management Systems:

We are in the midst of significant system transitions related to staff reductions, profound legislative actions, a new Governor, re-alignment with other state agencies, and internal re-organization, all of which are accompanied by uncertainty as well as anticipation. As such, it is with intention that Washington is submitting a MHBG plan that is similar to last year's plan. Additionally, this plan is for one year as MHD expects to move forward confidently with focused efforts to utilize our MHBG funding on the facilitation of transformation.

MHD's Vision for the Future:

For the Division:

- Continued efforts to increase expertise of a highly skilled workforce within MHD;
- Stability of hierarchy, cohesion of merged divisions, and staffing at adequate levels to accomplish the exceptionally challenging and important work that lies before the Division.
- Expansion and inclusion of consumer and family voice in Division efforts to guide the mental health system toward greater alignment with the over-arching goals of the President's New Freedom Commission recommendations (outlined in the Executive summary of this document) for improvements to the service delivery system.

For the State Mental Health System:

- Care that is based in ***Recovery*** and ***Resiliency***;
- Housing that is safe and affordable;
- Vocational opportunities quality of life activities that are meaningful and feasible;
- Services that are culturally competent and accessible to all who are eligible;
- Access to evidence based practices and services that are cohesive and well coordinated, demonstrating enhanced relationships between state agencies, RSN's, providers, Tribes, consumers, families, and communities, thereby facilitating a seamless continuum of care for recipients of mental health services in Washington State.

To achieve these goals, MHD will continue to focus its resources on the fundamental and imperative goal of ***Transformation*** through our STIs as they unfold. Additionally, we have changed the manor in which MHBG funds may be expended, directing focus of funds exclusively on services that support ***Recovery*** and ***Resiliency*** and services that are not expected to be performed with in the confines of the MHD contracts with the RSNs for Medicaid and State-Only funds.

Greater consumer voice and involvement has also been encouraged through the Division's MHBG contracts with the RSNs. This is evidenced by submission of a letter of review and comment from the respective RSN's Advisory Board with the RSN's proposed expenditure plan. Both the MHPAC and MHD have taken steps to support the education and empowerment of RSN Advisory Boards, which are also required to have >51% consumer/advocate/family member involvement. MHPAC will be receiving increased funding in 2007 to provide some education and liaison services to the RSN Advisory Boards. MHD has created a MHBG web-page located at http://www1.dshs.wa.gov/Mentalhealth/blockgrant.shtml to improve access, streamline the contracting and reporting processes as well as share and receive information. On this web-site, is an informative power-point presentation which has been shared at the MHPAC Annual Stakeholder's Meeting and forwarded to the RSNs for dissemination to their staff members and Advisory Boards. The goal again, is to educate and empower all parties in the value of this dynamic federal resource.

II. Significant Events Impacting Washington's Public Mental Health

- **RFQ/RFP Process**: The completion of the legislatively mandated RSN procurement process has resulted in the communication of clear expectations across the entire array of RSN responsibilities including quality, diversity, access, fiduciary responsibility, technical capability, program development. Through establishing these expectations, many RSNs were able to articulate their ability to provide the level of excellence in services sought by the state. For the RSNs that did not originally qualify, the RFP process provided an opportunity to shape and enhance their resources and continuum of services. In all, the procurement

process has resulted in clearer expectations to the RSNs and improvement in the ability of the RSNs to meet those expectations.

- **Funding for high intensity and hospital level of care**: Funding requested of the legislature by the new MHD Director, Richard E. Kellogg, was awarded to address critical concerns regarding insufficient inpatient capacity. The solution attacks the issue from two fronts: the short-term need for more inpatient beds at the state hospital and the long-term need for enhanced community supports through development of eight (8) teams to deliver the evidence based practice of Program for Assertive Community Treatment (PACT). As PACT teams are made operational, hospital wards will be closed. Washington's PACT teams will vary from the standard in that every PACT team will have a Peer Counselor. The decision on the part of the legislature to fully fund this initiative is indicative of the legislature's considerable level of understanding and commitment to meeting of the current needs of the public mental health system while investing in the future expectations for the provision of mental health services to be community-based.

- **Enhanced opportunity for system and community collaboration**: The Mental Health Division (MHD) is actively working to strengthen relationships with all stakeholders in the mental health system. Major partners include the Regional Support Networks (RSNs), consumers, families, MHPAC, Transformation Work Group, community mental health providers, state hospital patients, labor unions and allied systems. Some of these allied systems include formal systems such as the Children's Administration, the Aging and Disability Services Administration, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, the Office of Superintendent of Public Instruction, the Department of Corrections, and the Division of Vocational Rehabilitation, to name a few. As noted earlier, with the reorganization initiated by the DSHS Secretary, greater inter-agency collaboration is expected.

  MHD leadership and staff members meet regularly with RSN administrators and assure that there is representation from the RSNs on any committee created to develop or establish policy. These committees also include providers, consumers, parents and family advocates and at times, allied system partners. Topics for discussion range from the call for evidenced based practices to the need for Washington Administrative Code changes.

  MHD also meets with the Washington Community Mental Health Council, an association representing most of the community mental health centers that operate under subcontract with the RSNs to deliver direct services to consumers. MHD seeks and receives input as well from community mental health centers that do not belong to the council, but who subcontract with the RSNs.

  Another valuable tool for increased collaboration in the enhancement of a comprehensive community based system of care is the Inpatient Roundtable,

which is a technical assistance group comprised of staff from MHD, the Medical Assistance Administration, RSNs and community hospitals. This knowledgeable team has been on hiatus due to limitations related to the RFQ/RFP process, but will be reconvened and return to a schedule of routine meetings to discuss various issues that arise relating to community inpatient services. The Roundtable has historically worked diligently to find reasonable solutions, while offering creative ideas for system improvement.

In addition to building upon the formal system infrastructure above, the use of other community resource programs to strengthen and diversify the community mental health system are frequently utilized such as churches, food banks, homeless shelters, the YMCA and YWCA. The mental health system also relies on natural support systems such as friends and neighbors through the use of Individually Tailored Care Plans and Wrap Around services, which are consumer focused, strengths-based and needs driven.

- **Increased efforts to coordinate physical and mental health:** Washington's Medicaid Integration Project (WMIP), effective January 2005, came to fruition through the collaboration of DSHS with Molina Healthcare of Washington, Inc (Molina). The goal has been to manage and provide medical and chemical dependency services through Molina's provider network, with an initial requisite enrollment of 6,000 individuals (with option to dis-enroll) in a county north of Seattle. The focus of this new project is to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:
    - Prevent unnecessary hospitalizations;
    - Postpone placement in nursing homes;
    - Eliminate duplicate prescriptions; and
    - Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

  While WMIP was initially focused on integrating medical and substance abuse treatment, this pilot has been expanded to include individuals with mental illness, many of whom struggle with complex medical needs and substance abuse as well. Inpatient care related to mental illness will also be incorporated into the plan. Outpatient mental health services were recently added and are provided through Molina's approved network of providers consisting of licensed community mental health agencies. Together, all participants in WMIP are working to streamline and enhance the quality of care for Medicaid recipients enrolled in the pilot.

- **Increased avenues for consumer participation and representation**: A State-wide Consumer, Family and Youth Network is being developed under the leadership of consumer staff involved in the Transformation Grant. The intention is to help build an independent and sustainable coalition that will eventually attain

501(c) 3 status. The Network will facilitate a more unified consumer voice regarding the direction of the mental health system.

Another channel for adult voice will come through the creation this year of a seventh subcommittee to the MHPAC, which will be the Adult Sub-Committee. This group will assess and address the needs specific to adult consumers of the mental health system and is being developed at the request of consumer members of MHPAC. One of its first tasks is to review the job description for the Manager of the Office of Consumer Affairs (OAC); a position that is temporarily vacant.

OCA meets the requirements described in the MHD managed care waiver from the Centers for Medicare and Medicaid Services (CMS) and serves as an "independent" but internal component of MHD's Management Team, reporting to the Director's Office. OCA provides MHD staff and MHBG contract holders with liaison and consumer-run advocacy and support services. While OCA has held an active role in the State Behavioral Health Conference, trainings for Ombudsmen and Quality Review Teams, as well as resolutions of consumer complaints at the Division level, its primary program has been the "ORCA Conference Series" (Outreach, Recovery, and Consumer Advocacy).

ORCA is used to provide outreach and education services, while at the same time being utilized as a mechanism for voice collection through major conference events in each state region. Topics are consumer driven and follow the advocacy recommendations of CMS evaluations and MHD Quality teams.
Between OCA, the Adult Consumer Sub-Committee, and the Consumer, Family and Youth Network, opportunities for consumer's to provide input into the public mental health system have never been greater.

- **Expansion of Peer Counselor and Recovery training:** Consumer training and employment is also possible through a newly implemented comprehensive training and certification program for Peer Counselors. To fully integrate this service, the State's Medicaid Plan was recently amended to allow peer support as a billable treatment modality under the Medicaid State Plan. To be accepted for the MHD-sponsored training, an individual must self-identify as a consumer of the public mental health system with one year in recovery.

  *The term, **"consumer"** is defined in the Washington Administrative Code (WAC) and includes the parents or legal guardians of children under the age of 13 when they are involved actively in the treatment of the child.* Individuals applying for certification must be Registered Counselors with the Department of Health, must successfully complete forty hours of in-class training that is experiential and informational in format and the individual must pass both oral and written exams. Accommodations are provided for individuals with special needs and every opportunity is provided to enhance the success of the participants.

  Upon completion of the requirements for peer counselor based on the Medicaid

State Plan, a letter of completion is issued by the MHD verifying that the minimum qualifications have been met. Licensed community mental health agencies are beginning to hire and employ peer counselors to meet the requirement that all state plan services be available in each RSN. MHD anticipates expansion of peer support by continuing the trainings in the upcoming year and by enhancing an internet site devoted to this model of care focused on ***Recovery*** and ***Resiliency***.

Wellness Recovery Action Plan (WRAP) training was also provided this year to all certified Peer Counselors as well as others interested in this evidence-based program. This training series will result in 75 certified WRAP trainers in a "train the trainers" model. Discussion is also underway to provide WRAP training specific to a youth audience.

In an effort to increase collaboration between MHD and Transformation Grant initiatives, staff members from both entities have been meeting regularly to develop and implement ***Recovery*** and ***Resiliency*** trainings across life-span, socio-economic, and cultural/ethnic boundaries.

- **Increased focus on quality and accountability:** As part of quality management, there have been three MHD sponsored System Improvement Groups, which have included consumers, parents, family advocates, community mental health centers, Washington Institute for Mental Illness Research and Training (WIMRT), and Regional Support Networks. System Improvement Group recommendations have been incorporated into the Division's quality management plan and into the activities of program planning, policy direction, and contract development.

  On a state-level, the Governor has instigated GMAP (Government Management Accountability and Performance) which requires all state agencies to conduct business under the framework of measurable outcomes, quality services, and responsible finances. Every administration, division and agency within state government must demonstrate these GMAP expectations as evidenced by tying all budgeting activities to GMAP goals and indicators.

- **Increase resources for persons with co-occurring disorders**: MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee made up of providers from mental health, chemical dependency, other cross-systems and consumers. This group, having been in existence for approximately thirteen years, continually seeks to address the co-morbidity issues of mental illness and substance related disorders. The two divisions often engage in joint studies including developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

  Implemented over the past year has been the Omnibus Mental Health Reform Bill geared at enhanced and expanded services to persons with co-occurring disorders. This legislation lays the ground work for a truly integrated crisis system aimed at

providing the right services to dually-diagnosed consumers in crisis as well as attempting to reduce hospitalizations and jail recidivism. Specific provisions included:

- Establishment of a process to identify individuals with co-occurring mental illnesses and substance abuse disorders through the consistent use of standardized screening and assessment processes;
- Expansion of the use of therapeutic courts (e.g., drug, mental health and family therapeutic courts);
- Improvements in access to services by providing Medicaid processes so that someone released from jail or prison can have Medicaid benefits restored quickly so they receive the treatment they need to reduce the risk of re-offending;
- Improvements in access to inpatient services by creating a new facility licensure;
- Authorization for the creation of a combined mental and chemical dependency crisis response system in two pilot sites establishing secure detoxification facilities;
- Authorization for the creation of a combined mental and chemical dependency project to provide intensive case management services; and
- A mandate for the study of outcomes specific to both pilots.

Additionally, the State Legislature awarded $18.8 million dollars in state funds and $10.5 million in federal funds to more than double the chemical dependency treatment services to Medicaid-enrolled disabled adults.

- **Mental Health Insurance Parity:** With the passage of Substitute House Bill 1154, came another significant move toward ***Transformation***. This legislation held the requirement that insurance carriers in Washington State provide parity between mental health services and medical /surgical services. Specifically, co-payments, prescription drug benefits, out-of-pocket expenses, deductibles, and treatment limitations for mental health conditions must now be the same as those for traditional physical health conditions. This is a significant step forward in strengthening the continuum of care, increasing access to mental health services, and facilitating ***Recovery*** and ***Resiliency*** for thousands of Washington's residents who struggle with mental health issues, but for whom treatment has been beyond reach due to their financial limitations coupled with inadequate insurance coverage.

- **Olmstead Grant supported training to direct care providers:** Other resources used by MHD have included the SAMHSA issued Olmstead Grant, which was utilized for the design and implementation of cross-system trainings with the Aging and Disability Services Administration (including older adults and developmentally disabled adults) and the Division of Alcohol and Substance

Abuse. The grant was an annual $20,000 award for three years beginning in 2001. MHD was pleased to hear that the grant is expected to continue for an additional 3 years. This particular training was delivered across the state in 6 different locations. It was focused on residential providers and the development of cross-system crisis plans with multiple steps that can be utilized prior to calling the crisis line. Trainings also included presentations by individuals who have first-hand knowledge regarding local systems, involuntary treatment statute, and provided direction on concerns such as when to call the crisis line and what to expect from them. Resource guides were also disseminated specific to each state agency's eligibility requirements, contact information, and local level access.

- **DD/MHD Collaborative Work Plan:** Through this innovative working agreement, MHD and the Division of Developmental Disabilities have worked to improve access to services, appropriateness of treatment, and accountability for services. Its keys to success have been that fact that it is formalized in writing, funded through the legislature, and facilitated by the DD/MHD Cross-System Committee, with the support of state-wide regional coordinators and the written reports from monitors with national expertise. The results of this program have been profound. Over 173 residential slots have been created in the community for this population. As evidenced in the table below, more people are leaving the hospital than entering, fewer are being admitted, of those admitted, fewer are entering the hospital for the first time, fewer are being re-admitted once discharged, and the length of time between hospitalizations has increased dramatically:

Measurable Outcomes	1998	2005
Number of DD/MI consumers in WSH	93	29
Number of first time admissions	61	6
Number of re-admissions	32	1
Mean length of stay	171	129
Total Admissions	93	7
Total Discharges	75	13
Average number of days away between hospitalization	33.1	397.3

- **Support of Evidence Based Practices:** In addition to the upcoming development of PACT teams, demonstration of Washington's desire to promote use of evidence based practices is seen through MHD's contract with the Washington Institute of Mental Illness Research and Training (WIMRT) for the development and publication of an exceptional handbook titled, "Mental Health Best Practices for Vulnerable Populations" which includes, but is not limited to, evidence based practices for such traditionally underserved groups as sexual minorities, individuals with developmental disabilities, older adults, and individuals with diverse cultural issues such as Native American Tribes. This handbook has been provided to other states upon request in the service of technical assistance.

MHBG funds are also being used to support development of EBPs specific to Older Adults included training on the implementation and use of the evidence based practices of PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) for late life depression. MHD will continue to actively enhance the outreach capacity and specialized services needed by this traditionally underserved population.

MHD is pleased to share the results of the recently conducted Evidence Based Practice Provider Survey which was also completed under contract WIMIRT. The document in its entirety may be found in Attachment A of this report. It is considered a highly valuable tool in the promotion and implementation of EBPs in Washington.

- **Jail Services:** Through budget proviso, the legislature allocated 5 million dollars over the biennium for the provision of services to persons with mental illness who are incarcerated. Funds are being used to perform screenings on every person referred by the jail staff. From there, intakes are being completed on persons who fall under the legislatively defined "priority populations." Following this step, the Access to Care Standards (ACS) are applied. If a person is found to meet the ACS, then the RSN ensures that complete transitional services are provided, including resources to meet physical and mental health, residential, and financial needs. If the individual is not found to meet the ACS, then at the very least, the RSN is ensuring the submission of an application for available benefits to the Department of Social and Health Services. This process required multiple contractual agreements as well as over 60 Memorandums of Understanding (MOUs) across the state, moving the entire system toward greater collaboration in serving this population. These services have had a direct impact on the next bulleted item.

- **Expedited Eligibility:** Authorized by passage of SB1290 and funded through the Jail Services Proviso above (418K of the 5M), is the expectation that a review and determination of eligibility for TXIX services be expedited for persons who have a serious mental illness, who have been on TXIX or SSI some time in the past 5 years, who are currently residing in either a jail, prison, or state psychiatric hospital, and who are currently not receiving benefits. MHD has actively partnered with sister agencies, including Economic Services Administration, Department of Corrections, and Disability Determination Services, as well as the RSNs, jails, psychiatric hospitals, the Washington Association of Sheriffs and Police Chiefs (WASPC) and other interested stake holders to build this network of resources. Doing so is expected to reduce recidivism, decrease bureaucracy, and improve ***Recovery*** outcomes.

- **Improved Tribal Relations and Supports:** The establishment of a Tribal Liaison position stationed at MHD to provide coordination with Washington's 29

federally recognized tribes in addition to three non-federally recognized tribes has been an imperative part of the mental health and tribal coordination. Tribal members who are Medicaid enrolled retain the option to receive public mental health services through the RSNs or may choose to receive services through the tribal mental health system. The DSHS Administrative Policy 7.01 ensures MHD operates in a government-to-government relationship with the tribes. RSNs are also required to comply with the 7.01 Policy and must submit comprehensive plans to the MHD detailing tribal/RSN relations. A recent Memorandum of Understanding (MOU) was executed between DSHS and the Nisqually Tribe, recognizing the full faith and credit of tribal court orders for the first time. Other tribes have subsequently expressed interest in developing similar MOUs with DSHS.

Discussion is underway to consider a second Tribal Summit similar to the one held three years ago, convened to focus on mental health issues. Active participants included members of various tribal councils, native healers and spiritual leaders as well as the Director of the MHD and other state employees. Tribal Summit work groups focused on ways to decrease disparities in access to services while increasing the quality of care for the State's Native American population. In support of the Tribes, MHD has doubled the amount of MHBG funds obligated to tribal endeavors from 40K to 80K for FFY 2007. MHD is leading by example in hopes that the RSNs will also increase their support of the Tribes in their areas.

- **Increased focus on MHBG funds:** MHD has begun conducting on-site program and fiscal reviews of each RSN related to the use of MHBG funds. These reviews, which have resulted in significant improvements in accountability and consistency, have been followed up with technical assistance from MHD for those RSNs needing help in the development or enhancement of their tracking and monitoring policies, procedures, and accounting practices.

  In addition to increased accountability through monitoring, MHD has improved the process by which an RSN submits and receives approval for its planned use of MHBG funds. In support of paperwork reduction and to streamline and expedite the contracting process, MHD developed electronic forms for the RSNs to use in Initial Proposals, Contract Amendments, Progress Reports and Implementation Reports.

  Additionally, a new process for review of RSN MHBG plans has been developed. RSN MHBG plans were for the first time reviewed by a team of persons including MHD staff and members of MHPAC. The review team first applied the identified *guiding principles* and *spending categories* (see section III below "Expenditure of MHBG 2006 Funds"). The team then reviewed two newly required pieces of the proposal approval process: a narrative description of how the services it is planning on supporting will promote ***Transformation, Recovery or Resiliency*** and demonstrate that the RSN Advisory Board (which is required through WAC

to have >51% Consumer membership) has had involvement in development or review of the RSN's plan as evidenced by either meeting minutes or a letter of opinion on the proposed plan.

To support RSN Advisory Boards in providing informed and meaningful feedback to their particular RSN specific to MHBG, MHPAC invited the RSN Advisory Boards to its Annual Meeting last year. There, participants were shown a power point presentation which provided detailed education on the MHBG. Feedback regarding the Annual Meeting noted this particular training as one of the most valued parts of the event. An updated version of this was presented this year, but for the entire assembly at the meeting. Following this, it was posted to the internet, distributed electronically to all RSNs who were asked to follow-up with their respective Advisory Boards. The ultimate goal is to educate everyone about the MHBG so that these funds may be maximized to their fullest potential in moving Washington toward ***Transformation.***

Within the Department of Social and Health Services and other state agencies including Juvenile Rehabilitation Administration (JRA) and the Children's' Administration (CA) a number of initiatives have been undertaken towards improving cross systems collaboration in an effort to enhance development of a comprehensive community-based mental health system specific to children and youth.

- **Select Committee on Adolescents in Need of Long-Term Placement**

Of significance is the establishment of a taskforce to study the highest need youth served by multiple systems within the department. This taskforce, known as the Select Committee on Adolescents in Need of Long Term Placement, was made up of community leaders and advocates, including members from the Consumer, Family and Youth Network, as well as DSHS administrators. The Committee published its final report in December 2002 making recommendations for improving the services and outcomes for youth with the highest need.
The MHD 2003-2005 contract with the RSNs includes a requirement for the RSNs to use treatment interventions that are research-based and shown to be effective in achieving positive outcomes when providing mental health services to children and youth. This requirement is the result of a recommendation of the Select Committee on Adolescents in Need of Long Term Placement.

- **Treatment Foster Care Taskforce**

Acting on these recommendations, the DSHS Children's Administration (CA) formed the Treatment Foster Care Taskforce. This taskforce met during 2003 to review the foster care system. It made recommendations of the type of foster care and treatment most likely to be effective and beneficial with high need youth in the foster care system. The final report is in draft form only and has not been published.

- **MHD/JRA Development Of Cross Systems Protocols and Transition Agreements**

MHD and the Juvenile Rehabilitation Administration (JRA) worked together to develop cross systems protocols and transition agreements between each of the Regional Support Networks (RSN) within the public mental health system and each of the corresponding JRA regions. These agreements, completed in 2003, facilitate a smooth transition from JRA facilities to the community for youth who have mental health diagnoses.

- **MHD/CA Development of Cross Systems Protocols and Dispute Resolution Agreement**

MHD included in its 2001-2003 contracts with the RSNs, a requirement that each RSN develop cross-system service delivery protocols for the coordination and integration of services with each of the DSHS CA Regions. Protocols were completed in October 2003 and presented at a December 2003 joint meeting of the RSN Administrators and CA Regional Administrators attended by the Assistant Secretaries of the Health and Rehabilitative Services Administration (HRSA), CA and JRA. The 2003-2005 RSN contracts with the MHD include a requirement that the RSN implement these protocols. In addition, a Dispute Resolution Agreement between MHD and CA was finalized after meetings which included input from the RSNs, CA regions and DSHS headquarters staff.

- **SAMHSA Planning Grant Received for the Implementation of Evidence-based Practices**

In October 2003, the MHD received a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant for the development of the use of evidence-based practices. Efforts to identify and plan for the implementation of evidence-based practices (EBPs) are underway with a workgroup consisting of service systems stakeholders.

- **Children's Mental Health Initiative**

Especially significant is the Children's Mental Health Initiative (CMHI) which grew out of DSHS Leadership's commitment to respond to concerns and improve care delivery. The Children's Mental Health Initiative (CMHI) represents a sustained commitment on the part of DSHS and the assistant secretaries of HRSA, CA and JRA to provide better coordination of services for children and youth with complex mental health and social needs. Children and youth whose needs span one or more of the child serving systems represent the costliest care and the greatest coordination challenges and are the target population for this initiative.

CMHI leadership includes a director-level committee that meets regularly to steer the project and advise the assistant secretaries on a regular basis. Staff members from each administration meet to coordinate independent and joint efforts related to the

implementation of evidence-based practices (EBPs). Considerable progress has been made guided by the following vision of "improved mental health services for children and youth":

I. Services and supports are evidence-based and service providers are well trained in these practices.

II. There is movement towards "integration of business services," including simplified access, joint contracts, and sharing of some system resources.

III. The Department partners with tribes, minority communities and other interested parties to foster promising practices achievement of evidence-based practice status.

IV. Family and stakeholder voice is valued and incorporated into planning.

Progress includes:

- Implementation of Evidence-Based Practices
- Integration of Business Practices
- Tribal and Minority Collaboration
- Family and Stakeholder Voice

I. Implementation of Evidence-Based Practices

Many mental health practices, including therapy interventions, have been studied to determine how effectively they impact the lives of children, youth, and families. Within the child/youth populations served by DSHS, effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; avoidance of higher cost and more restrictive levels of care such as children's long-term inpatient treatment, and reduced levels of juvenile crime.

The current work of CMHI includes implementation of five EBPs:

- Multidimensional Treatment Foster Care (MTFC)
- Functional Family Therapy (FFT)
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Family Integrated Transitions (FIT)
- Multi-System Therapy (MST)

DSHS CMHI chose these EBPs on the basis of the recommendations of an "expert panel" of researchers from across the state. These practices range from institutional and out-of-home (treatment foster care) to community and home-based interventions all

designed to avoid placement or placement disruption and reduce the need for chronic and/or institutional care. To date, progress includes:

- The expansion of MTFC, to include 30 additional treatment foster care beds for the Children's Administration and 10 treatment foster care beds for youth with primary mental illness and behavioral disorders in the Mental Health System.

- Statewide training in Trauma-Focused Cognitive Behavioral Therapy expected in its first round to result in treatment teams having the capacity to serve 1,440 youth annually. Training will include six months of bi-weekly consultation with national and local trainers to ensure fidelity and appropriate adaptation where needed.

- Early collaboration between MHD, JRA and DASA to expand implementation of FIT for youth with co-occurring substance abuse and mental health disorders in facility and community based care. This will likely mean additional contracting by the Department with FIT model developers at the University of Washington, Division of Public Behavioral Health and Justice.

- Expansion of Functional Family Therapy through Children's Administration, which has previously been available only within JRA.

- A children's mental health track with emphasis on evidence-based practices for youth was sponsored by the Mental Health Division at the annual Washington Behavioral Healthcare Conference, June 14-16, 2006 in Wenatchee, WA, and covered issues related to trauma, ethnicity, and substance abuse.

Additionally, the 2006 Legislative Budget included an allocation of $450,000 to support and study the implementation of an evidence-based pilot program addressing the mental health needs of youth as determined within the community through an RFP process. This pilot will be operational by January 2007.

II. Integration of Business Practices.

CMHI is developing an instrument with the assistance of the Washington State Institute on Public Policy (WSIPP) that will be used by all three administrations to match children and youth to the appropriate evidence-based practice or practices. This domain-based tool will be modeled upon WSIPP's Washington State Juvenile Court Assessment and will create the foundation for prospective cross system efficiencies to be employed in assessment and case-management.

III. Tribal and Minority Collaboration

A number of forums have been held with researchers and providers representing diverse ethnic, minority and tribal groups that have addressed the perceived effectiveness and cultural relevance of EBPs. Discussion is ongoing and commitment is firm on the part of DSHS to explore potential funding strategies to support the evolution of promising

practices, particularly those in use by tribes and minority communities, into evidence-based practice status.

IV. Family and Stakeholder Voice

The Department is involving parents and families in an ongoing way to share information and gather input – assuring a formal feedback mechanism for updates and stakeholder input through:

- Semi-annual meetings with families and youth
- Contracting with Statewide Action for Family Empowerment of Washington (SAFE-WA) to provide orientation to parents regarding EBPs
- Potential creation of a Parent/Family Advisory Group

CMHI is a high priority of the Secretary of DSHS who has directed the Assistant Secretaries to support the project and ensure accountability and ongoing partnership. To ensure effective coordination among many stakeholder groups and initiatives, MHD regularly updates and obtains input from the children's subcommittee of its Mental Health Planning and Advisory Council (MHPAC) and coordinates with the Mental Health Transformation Grant.

Additionally, in 2005, the Division of Alcohol and Substance Abuse (DASA) received a Statewide Coordination Grant from SAMHSA Center for Substance Abuse Treatment (CSAT) to develop a statewide infrastructure that fosters cross system planning, knowledge and resource sharing to enhance the existing adolescent substance abuse treatment system. The Mental Health Division, Children's Administration and Juvenile Rehabilitation Administration participate in the Statewide Leadership Council and subcommittees of this grant chartered to address resource gaps and improve licensing and certification standards, training in evidence-based practices and treatment integration through cross system collaboration.

Other system-wide activities of achievement include:

- Development of Governor's Department of Early Learning
- Legislative support through funding several EBPs for children/youth
- Youth membership on the Children's sub-committee for MHPAC
- MHD staff member appointment to the State Interagency Coordinating Council, which serves in an oversight/advisory role to the Infant Toddler Early Intervention Program (ITEIP). ITEIP is Washington's Individual with Disabilities Education Act (Part C) program for children ages 0-3.
- Development of two pilot projects through the Health and Recovery Services Administration and the State Department of Health to address early intervention for maternal depression, serving as a preventative measure affecting infant development and decreasing potential for children to develop Serious Emotional Disturbance.

- Ongoing seclusion and restraint grant at the state psychiatric hospital for children, Child Study and Treatment Center.

Over the course of many biennia, training and technical assistance on the use of innovative methods of cross-system partnerships to deliver coordinated care have been provided. In addition, numerous local and national reports on coordinated care and best practices have been written. What has not accompanied this, however, is the funding and high level commitment in allied systems of care to support the growth and cohesion of children's services.

Imperative to the development of an effective system of care for children with SED and their families is collaboration. In an effort to reduce gaps in care, improve consistency of supports, and reduce duplication of services, MHD is working closely with other DSHS agencies such as the Juvenile Rehabilitation Administration and the Children's Administration in creating the Children's Mental Health Initiative. Through this joint venture, all parties hope to increase resource management and find better ways to incorporate evidenced based practices with the ultimate goal being improved care with demonstrated outcomes for children with complex, multi-service needs.

III. Expenditure of MHBG 2006 Funds (Purposes, Recipients, Activities)

Total State Expenditures for Community Mental Health Services

State Expenditures for FY 1996	$138,450,391
State Expenditures for FY 1997	$142,120,995
State Expenditures for FY 1998	$144,140,536
State Expenditures for FY 1999	$146,062,262
State Expenditures for FY 2000	$141,273,152
State Expenditures for FY 2001	$153,423,628
State Expenditures for FY 2002	$156,227,188
State Expenditures for FY 2003	$160,865,058
State Expenditures for FY 2004	$162,114,757
State Expenditures for FY 2005	$177,398,418
State Expenditures for FY 2006 (estimate)	$228,979,741
State Expenditures for FY 2007 (estimate)	$225,895,741

Of the estimated 8.4 million dollars in Community Mental Health Block Grant funds awarded to Washington State, 5% (grant limit) was obligated to the state for administrative costs associated with the grant. Of the *remaining* 95%, 80% was allocated to the RSNs and was contracted out through a historical distribution formula which, under the advisement and support of the MHPAC, has been changed to a population-based distribution formula for FFY 2007. The final 20% (approximately 1.5 million) was utilized by MHD for selected activities. In determining which initiatives would be supported with MHBG funds in FFY 2006, the following list of *guiding principals* was developed, against which all proposals were measured. To be funded as part of the 20%,

activities were required to:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;

2. Work in tandem with the Division's Strategic Plan which, has been updated in collaboration with the MHPAC to incorporate the ideals of "Achieving the Promise: Transforming Mental Health Care in America";

3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family voice;

4. Link well to other resources and transformation activities;

5. Meet needs in the system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and

6. Align well with other Division initiatives or legislatively mandated expectations.

For FFY 2006, the focus of MHD's portion of the grant was in support of the following:

- **Consumer, advocate, and family voice** driven and promoted activities
- **Vocational** initiatives that lead to meaningful employment
- **Residential** resources that promote safe and affordable housing
- **Tribal** supports that improve infrastructure and services to tribal communities
- **MHPAC** resources that ensure consumer participation continues to increase and that state-wide diversity is represented
- **Data Development** to validate success our areas for improvement

The primary ways in which these focused areas were supported include:

- **Conferences** such as those for co-occurring disorders, behavioral healthcare, foster care, early intervention, ethic minorities, and youth/parent advocacy.
- **Trainings** for issues or populations such as disasters, assisting consumer's in applying for Medicaid, increasing housing access, implementation of evidence–based practices, CIT for law enforcement, targeted trainings for geriatric specialists, ethnic minority specialist, chemical dependency specialists, older adults specialists, Ombuds, and peer support counselors.
- **Research and data collection** on such things as evidence–based practices, consumer satisfaction, club houses, and co-occurring disorders.

Below, a table reflecting the budget breakout as described above is provided. One may note a row reflecting 420K for MIO. This is the Mentally Ill Offenders Community Transition Program which initially began as a pilot program using State-Only funds. When the request was made to continue funding the program in 2004, the state legislature obliged, however it required through proviso language that the program be continued utilizing MHBG funds. Despite the protests of MHPAC, MHD has had to continue to support the MIO program through MHBG funds secondary to legislative mandate.

FFY06 MHBG Distribution

Annual Estimated Grant Award		$	**8,400,033**
Grant Administration (5%)		**$**	**420,002**
Balance for RSN's and Other Activities		$	**7,980,031**
RSN's total (80% of the 95%)			
MIO Program		**$**	**451,000**
Contracted to Regional Support Networks		**$**	**5,933,000**
Other Plan Activities		**$**	**1,596,031**
Contracted to Regional Support Networks			
Chelan Douglas	1.30%	$	77,000
Clark County	3.85%	$	228,000
Grays Harbor	1.31%	$	78,000
Greater Columbia	10.53%	$	625,000
King County	29.69%	$	1,762,000
North East Washington	1.05%	$	62,000
North Central	3.52%	$	209,000
North Sound	11.23%	$	666,000
Peninsula	4.49%	$	266,000
Pierce County	18.13%	$	1,076,000
South West	1.76%	$	104,000
Spokane County	8.19%	$	486,000
Thurston/Mason County	3.43%	$	204,000
Timberlands	1.52%	$	90,000
Total	100.00%	**$**	**5,933,000**

The contracted activities of each RSN are reported in the Performance Indicator section under the specific Performance Indicator to which they relate. However, below are some examples of RSN activities supported with MHBG funds in 2006:

- Peer Counselor Training
- CIT training
- Housing Development
- ICCD Club House Development
- Recovery and Resiliency Training
- Stigma Reduction Consumer & Family Education

- Geriatric Outreach
- WRAP training
- Supported Education
- EBP training
- COD training

IV. Mental Health Planning and Advisory Council:

MHPAC Accomplishments:

The Washington State Mental Health Planning and Advisory Council met 11 times during 2006. The June meeting was on the eastern side of the state. The meetings of the seven standing sub-committees ranged from quarterly to every other month with telephone conference calls in the off months. The Council and the sub-committees have worked diligently and successfully to meet its Vision, Mission, and Goals as listed below:

VISION:

Plan, Advocate, Evaluate

MISSION:

To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

GOALS:

The Goals of the Mental Health Planning and Advisory Council shall be to transform the mental health system consistent with the goals of the President's New Freedom Commission on Mental Health, as follows:

Primary Goals:

A. Washington State residents acknowledge that mental health is essential to overall health.

B. Mental health care is consumer and family driven.

C. Disparities in mental health services are eliminated.

D. Early mental health screening, assessment and referral to services are common practice.

E. Excellent mental health care is delivered and research is accelerated.

F. Technology is used to access mental healthcare and information

Other Goals:

A. Oversee the Federal Block Grant, including recommending the plan, amendments and reports submitted by the Mental Health Division to the Center for Medicaid and Medicare Services.

B. Develop and take advocacy positions concerning legislation, funding and regulations affecting mental health services through the use of mental health statistics for decision making and planning.

C. Support and advocate for quality, cost effective and individualized consumer/family based services through evidence based best practice models of care. Support research and use of promising practices through continuous quality improvement.

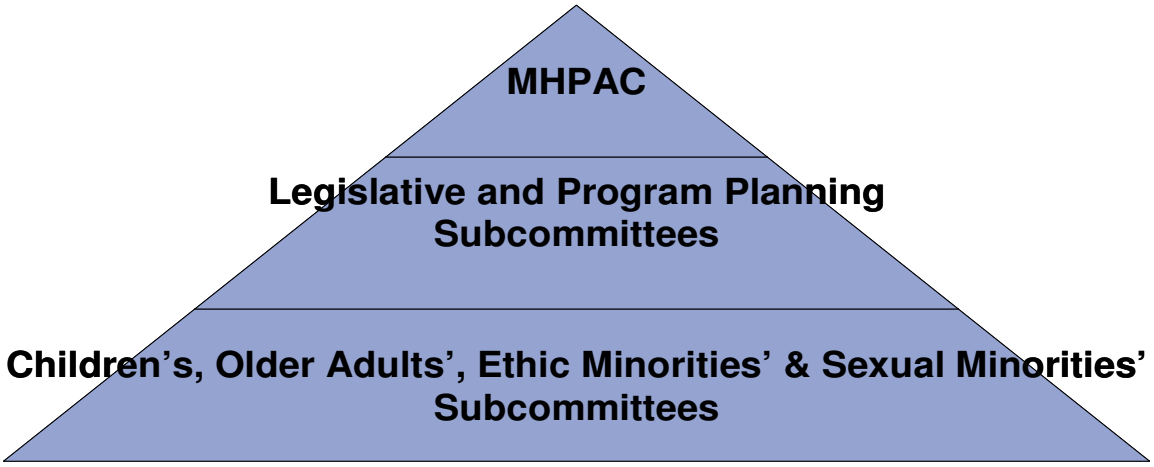
D. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults. Services shall be focused on ***Recovery*** and ***Resiliency*.**

E. Support education about mental illness and other mental disorders in an effort to reduce stigma.

As a result of the Council's two trainings by the National Association of Mental Health Planning and Advisory Council and the National Technical Assistance Center for State Mental Health Planning, as well as attendance at national conferences, the Council reorganized its structure to establish the following standing subcommittees to carry out its Vision and Mission and to fulfill its Goals and Other Duties:

- Legislative/Administrative Subcommittee,
- Program/Planning Subcommittee,
- Children's Treatment and Services Subcommittee,
- Sexual Minority Treatment and Services Subcommittee,
- Older Adult Treatment and Services Subcommittee, and
- Ethnic/Cultural Minorities Treatment and Services Subcommittee.

For communication purposes, the Planning Council is at the apex of a triangle. The Legislative and Program/ Planning Subcommittees are the next step down. The four remaining Subcommittees form the base of the triangle.



Note: At the July 2006 MHPAC meeting, a vote of affirmation and approval came for the addition of another subcommittee called the Adult Consumer Subcommittee, which is comprised solely of adult consumers.

A representative of each Standing Subcommittee is designated in the Bylaws as a member of the Planning Council. Each Standing Subcommittee is charged by the Planning Council to focus their attention on the implementation of the Goals and Purpose of the Planning Council. Therefore, on the Planning Council Meeting Agenda, Subcommittee reports reflect the Planning Council Goal being discussed or implemented.

Through the trainings the MHPAC has received from the National Association of Mental Health Planning and Advisory Council and the National Technical Assistance Center for State Mental Health Planning, the Council has been infused with a thorough understanding of the President's New Freedom Commission on Mental Health report, Achieving the Promise: Transforming Mental Health Care in America. As a direct result, the MHPAC changed its Bylaw goals to include the New Freedom Commission goals as well as other MHPAC goals outlined above.

Further related to this increased expertise has been the MHPAC's focus on increasing consumer and family involvement at the onset of MHD policy, planning, and implementation endeavors. This has lead to a change of culture at the Division which supports the common goal of improving the quality of life for adults with severe mental illness and children with serious emotional disturbances.

In an effort to further the development of MHPAC skills and knowledge related to MHBG and national trends, MHD supported six (6) MHPAC members in attending the Joint National Conference on Community Mental Health Block Grants and Mental Health Statistics held in Washington, DC May 30th – June 2nd, 2006. This was a valuable opportunity for the Council members, who not only gained resources and expertise, but who provided valuable input to the conference through their participation. As a result of their attendance, the Council will pay greater attention and request more involvement in the State Plan.

Before listing the accomplishments of the MHPAC over the last year, it should be noted that the work of the sub-committees has served not only to forward the mission and goals of the MHPAC, but to bring greater awareness and understanding to their representative populations through advocacy as well as sponsorship of conferences, trainings, and community education projects. Additionally, the Council voted in its July 2006 meeting not only to add the Adult Consumer Sub-Committee, but to add a representative from the Aging and Disabilities Services Administration, bringing the full Council membership to 31.

The following is a list of the MHPAC accomplishments for 2005-2006 has been prepared by the Chair of the MHPAC for inclusion in this document:

COUNCIL'S INVOLVEMENT WITH THE MENTAL HEALTH DIVISION

I. Director level
   A. Participated on the interview panel for selecting a new MHD Director
   B. Participated on the interview panel for selecting a new Assistant Director
   C. Meets with the Director on a quarterly basis
   D. Director has attended and participated in 3 Council meetings.
   E. Assigned MHD Administrator is a Council member.
   F. Upon Director's request the Council has given input on the following:
      1. Role and responsibilities for the Office of Consumer Affairs
      2. Improving MHD's relationship with the 29 Sovereign Native American Tribes, including contracted funding.
      3. MHD Performance Indicators with the Vice Chair membership in Work Group
      4. MHD staff meetings.

   G. MHD Director a panel member at the Council's Annual Meeting. The topic was Integration/ Disintegration. This looked at the 4 models: CMS's Medicaid/Medicare, SAMHSA's Evidence Based Practices, Transformation Grant's Recovery and Resiliency and Washington State's WAC's/ legislative mandates.

II. Division level
   A. Three Council members participated in the RSN/RFQ selection process.
   B. Two Council members participated in the RSN/RFP selection process.
   C. MHPAC Chair and 4 Council members (Agency reps, consumer and parent with SED minor) are members of the MHD's System Transformation Initiative Task Force.
   D. Council working on more involvement in MHD's Strategic Plan.
   E. Council member participants on Performance Indicator Work Group.
   F. Reviewed Western Washington Hospital's consumer participation activities.

III. Federal Block Grant level
   A. Reviewed and made recommendations to the MHBG Application and Implementation Report. Once again, did not recommend the use of MHBG funds for the MIO program which was legislatively mandated and not reviewed by the Council.

B. MHPAC Chair and Council member reviewed the RSN contract applications for MHBF funds. Council did not recommend the MIO section and the Pierce and Peninsula RSN use of MHBG money on Crisis Triage Centers.

C. Approved and participated in Idaho's peer review of our MHBG programs in Spokane.

D. MHD's Federal Block Grant allocation covers the following:

1. MHPAC Council and the 7 Council Subcommittees meetings and travel /lodging costs for consumers, parents with SED minors and advocates. One Council meeting was held on the east side of the state

2. Travel and lodging for 5 Council members attending the SAMHSA annual June Conference in Washington, D.C.

COUNCIL'S ROLE IN PROMOTING TRANSFORMATION IN THE STATE

In the spring of 2005, the Council made a strong recommendation to the MHD Director to apply for a SAMHSA Transformation Grant. Council members attended meetings with the writers of the State's Transformation Grant. The Council wrote a letter of endorsement sent by the Governor with the State's Application. The State was awarded one of the original SAMHSA Transformation Grant in the fall of 2005. At the time of the award, the Governor appointed TWO Council members to the Transformation Work Group (TWG). Due to the high profile of the Council's membership, the TWG membership also included 4 additional Council members who are representing their agencies. The following list include some of the Council's activities in its on-going role in promoting transformation in the State's mental health system through its active involvement in promulgating the activities of the Transformation Grant.

Before and after the transformation grant was awarded to the state, the transformation staff often attended the regularly scheduled Council meetings. One of the Transformation staff is a Council member. Another staff serves as a non-member on a subcommittee.

Beginning with the first TWG meeting in the fall of 2005, the 2 Council representatives have been active participants in the transformation process at this top level and have attended each of meetings held every other month in all areas of the state. Council members have also made 2 trips with the Transformation Grant staff to Washington, D.C. to provide updates to SAMHSA.

In January of 2006, the Council Chair participated in the selection of Co-Chairs and members of the 7 Transformation Grant Subcommittees. By the final posting, 3 Council members served as Co-Chairs of 3 of the 7 Subcommittees. Each of the 7 Transformation Grant Subcommittees had at least 1 Council member serving as a Subcommittee member. Over the next 6 months, the Subcommittees were involved in over 40 public input sessions which occurred in all sections of the state and Regional Support Network (RSN) listening sessions. Obviously, the Council members were extremely involved and very committed to transformation.

In January 2006, the Council reviewed the Guidelines of the Transformation Grant Subcommittee. The Council recommended that the "categories did NOT reflect individual recovery and resiliency". The Transformation staff subsequently eliminated the "categories" from the Guidelines of TWG Subcommittees.

In March 2006, the Council spent most of its monthly meeting discussing and making recommendations on the Four Transformation Grant Questions. These Four T Grant Questions were the focus of each of the Transformation Subcommittee's public input sessions. On March 17, 2006, the Council sent a letter to Ken Stark, Director of the Mental Health Transformation Grant which included the following: summary of the Council member's consensus on questions 3 & 4; a listing of the themes of those responses and the need to respond to all of the Target Populations; and the Council's list of outcomes that they recommended for a Transformed System.

Throughout the spring and summer of 2006, Council members were involved in the TG Subcommittee meetings and the TG Task Group and Subcommittee meetings. At the conclusion of these meetings, 27 Outcomes Summaries by Subcommittee were agreed to by the TWG at its June 2006 meeting.

In August 2006, the Council discussed and gave recommendation on the Executive Summary of 2006 Washington Mental Health Transformation Plan: Phase I. The second half of the Council meeting was spent on prioritizing the Council top 3 (of the 27) Outcome Summaries by Subcommittee. On August 15, 2006, the Council sent 2 letters to Ken Stark, Director of the MH Transformation Grant. One letter focused on the Council discussion and recommendations regarding the Executive Summary. The second letter discussed the Council's decision to focus on "themes" in the Outcome Summaries by Subcommittee rather than prioritizing. This information was provided to the TWG at its August meeting.

In October 2006, the Council revisited the 27 Outcome Summaries by Subcommittee as the Governor had directed the Transformation staff that 27 was obviously too many outcomes and the focus needed to be on 3-5. Therefore, the Council did prioritize 3 of the 27. This decision was sent in a letter to Ken Stark, Director of the M H Transformation Grant and subsequently voted on at the August TWG meeting by the 2 Council representatives.

Beginning in the fall of 2005 and continuing throughout 2006, 1-2 Council members have actively participated in the formation of the Community Transformation Partnership (CTP). This is a coalition of mental health consumers, youth and family organizations who assisted in the preparation of the Washington State Transformation Project proposal, or actively advocate for mental health transformation goals and who share the goal of creating an inclusive statewide structure to transform the state's mental health system. CTP involves 12 entities which over the year have worked hard in collaborating in the development and delivery of a series of Recovery and Resiliency Workshops throughout the state and supporting the development and implementation of the (first) Washington State Mental Health 2006 Consumer Conference "Living With Purpose: Honoring Spirit,

Mind and Body". A Council member received a major award at this Conference.

SUMMARY STATEMENT
The Council has demonstrated an active involvement with the state's Mental Health Division and has participated extensively in the implementation of the Mental Health Transformation Grant. However, these two activities do NOT encompass all of the Council's work. For further accomplishments, please review the attached lists from the Council's seven (7) Subcommittees:

MHPAC/PROGRAM AND PLANNING SUBCOMMITTEE ACCOMPLISHMENTS
The Program Planning Subcommittee meets every other month face to face and has telephone conference calls every other month. Below are some of its accomplishments.
• COUNCIL MEMBERSHIP * On-going monitoring (for absences) of Council members. * On-going recruitment of Council members following geographical distribution, adequate representation of parents with SED minors, and all federal mandates. * Utilized a standardized Interview Questions and procedures for recruiting new members. * Developed a Handbook for new members.
• ANNUAL COUNCIL SERVICE EXCELLENCE AWARDS MEETING * Planned and implemented the Annual Council meeting which was hosted by MHPAC's Sexual Minority Subcommittee in 2006. * Utilized the previous year's standardized procedures, timelines, and guidelines for the Annual meeting. * Contacted CMS, SAMSHA, MHD and Transformation grant for Panel participants.
• BYLAWS CHANGES * Recommended the addition of an Adult Consumer Subcommittee to the By-laws. * Recommended the addition and recruitment of a Council member representing DSHS's Aging and Disability Service Administration.
• ANNUAL COUNCIL PROJECT * Reviewed suggestion of using the RSN's RFQ replies to Section 3.1.5 Promoting Recovery and Resiliency Requirements. Recommended that is was not "doable". * Recommended and set timelines to focus on its federal mandate of monitoring the Federal Block Grant monies by monitoring the RSN/FBG contracts and the MHD's budget for FBG monies. * Investigated ways to interact and integrate the Council with the RSN's Advisory Councils
MHPAC/LEGISLATIVE SUBCOMMITTEE ACCOMPLISHMENTS
• Assisted in further defining Washington State's Age of Consent Law

• Updated and distributed the new brochure
• Encouraged passage of HB 5763 and SB 1290 with few gubernatorial vetoes a. This prepared the way for MHD to require RSN participation in the RFQ process and b. Realignment of RSN boundaries c. It also redefined liquidated damages
• Participated in the MH Transformation Grant process, including members co-chairing and sitting on many of the subcommittees
• Oversaw continuing implementation of the insurance parity law
• Homelessness was addressed at the state level, with many grants offered
• Encouraged introduction of bill for independent Ombuds
• Encouraged introduction of bill for consumer-run club houses (this bill will be re-introduced in the 2007 Legislative Session).
MHPAC/CHILDREN'S SUBCOMMITTEE ACCOMPLISHMENTS
• Reviewed training on and provided input to the MHBG Plan
• Reviewed and provided feedback regarding the MHD Performance Indicators report
• Reviewed and provided input regarding the Department of Health "Statewide Needs Assessment"
• Explored process for making the Children's Subcommittee more meaningful and relevant to youth members
• Selected the recipient of the Ann Russell-Yeh Award as well as the recipient of the certificate of recognition and presented the award and certificate se at the MHPAC Annual Meeting in Sept.
• Actively recruited 7 new members including youth from Clark County
• Participated in the Transformation Work Group (TWG) and Subcommittees of the MH Transformation that produced the work plan required by SAMHSA (due Sept. 30, 2006).
• Provided consultation to the DSHS Children's Mental Health Initiative (CMHI), a joint effort of the Mental Health Division of the Health and Recovery Services Administration, Children's Administration and Juvenile Rehabilitation Administration

MHPAC/ETHNIC MINORITIES SUBCOMMITTEE (EMAC) ACCOMPLISHMENTS
• EMAC has participated significantly in the Mental Health Transformation Workgroup and subcommittees. EMAC's contributions have been significant to different groups within and around the state.
• The Minority Mental Health Training is in progress. This 100-hour training course will assist people to fulfill partial requirements as Mental Health Specialist.
MHPAC/SEXUAL MINORITIES SUBCOMMITTEE ACCOMPLISHMENTS
• Joint sponsorship with Division of Alcohol and Substance Abuse (DASA) for the *Saying it Loud* conference held in May 2006
• Completion of *Sexual Minority Specialist* standard (now in review)
• Hosting of the 2006 Mental Health Planning and Advisory Council annual meeting and presentation of the MHPAC Exemplary Service Award (held in September 2006)
• Completion and distribution of the *Resource Guide-Working with GLBTQ*
• Sexual Minority representative (Douglas Johnson) from Washington State to the annual SAMHSA meeting in Washington DC (June 2006)
MHPAC/OLDER ADULTS TREATMENT AND SERVICES SUBCOMMITTEE (OATS) ACCOMPLISHMENTS
• Reviewed and added a geriatric influence to the Transformation Grant application.
• The committee sponsored the first of three Transformation Grant Older Adult Subcommittee meetings.   ○ We also were able to place two subcommittee members on the Older Adult Transformation Subcommittee.
• One of the Older Adult Members chaired the Transformation Grant's Evidence Based Subcommittee.   ○ OATS reviewed known older adult EBPs and made recommendations to the Transformation Grant EBP subcommittee.
• Began development of an Older Adult Member Orientation Manual
• Participated in the 2006 Federal Block Grant review, requesting dollars be earmarked for older adults.
• Reviewed and suggested changes to the Mental Health Division Strategic Plan to better include older adult issues.

- Reviewed State Mental Health Division FY 2004 Performance Indicator data as it pertained to older adults and then noted increasing trends of less service to older adults.

- Began preparation of briefing paper in anticipation of meeting and informing the Mental Health Division Director at the November OATS meeting as to how the current mental health system is doing with providing services to older adults.

MHPAC ADULTS CONSUMER SUBCOMMITEE ACCOMPLISHMENTS

- The dream of an Adult Consumer Subcommittee became a reality. The age range of 18 – 59 represents the largest number of consumers receiving services in the system.

- Necessary Bylaw changes were drafted and approved by MHPAC.

- The Adult Consumer Subcommittee has had two organizational meeting in 2006 with a core group of 8 seasoned consumer advocates.

- The activities we have accomplished so far include:

  - Drafted a Mission Statement
  - Drafted a Vision Statement
  - Drafted a list of recommendations for the reorganization of the Office of Consumer Affairs
  - Drafted a list of hiring recommendations and personal qualifications for the new Office of Consumer Affairs Director
  - Drafted a meeting schedule for next year 2007 with meeting to be held the day before MHPAC meetings to reduce travel expenses.
  - Scheduled the February meeting to run concurrently with the Legislative Subcommittee and will be held in Olympia in order to meet with Legislators and their staff
  - Developed a list of priority projects for 2007 including :

    a. Concerns expressed by consumers statewide about TANF services including privacy and confidentiality issues,

    b. Lack of parity between services that families receive that single people do not

    c. Getting more consumers to utilize and develop their Advance Directives and getting providers to respect and follow the information

in the document

d. Concerns that some Mental Health Professionals are reluctant or outright refuse to go out in the field to access consumers that may be or have a history of violence,

e. Using bed space availability as a criteria in part for ITA commitment

f. Developing safe alternatives to commitment and the Designated Mental Health Professional responsibility to the caretaker who will be with the consumer till the crisis subsides (because of concerns that if the consumer still deteriorates the caretakers can't get a hold of the Designated Mental Health Professional or they don't respond in a timely manner)

g. Many complaints about the monitoring of Least Restrictive Alternatives (LRA's)

The following is an embedded copy of the requisite letter from the MHPAC regarding its review, input, and endorsement of this application. The signed original was mailed to SAMHSA as per request.

MHPAC Letter of Review and Recommendations:

Mental Health Planning & Advisory Council

Vision
Plan, Advocate, Evaluate
Mission
To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

Joann Freimund, Chair
3739 Goldcrest Hts. NW
Olympia, WA 98502
(360) 866-1575

November 9, 2006

LouEllen M. Rice
Grants Management Officer
Division of Grants Office, Room 7-1079
Division of Grants Management,
SAMHSA
One Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

The purpose of this letter is to inform you that the Washington State Mental Health Planning and Advisory Council (the Council) unanimously approved at its November 8, 2006 meeting the state's FY 2006 Mental Health Block Grant Implementation Report.

The Council received the Report a week ahead of time, allowing for comprehensive review and hearty conversation. Since one of the Council's major concerns was related to the data reporting section, discussion focused on this area. At issue was the fact that the report noted that while Objectives were obviously ACHIEVED, 18 of the estimated year-specific targeted percentages were NOT ACHIEVED. At the time of the Council's review, 22 targets were still not reported due to MHD difficulties with delayed data collection from other sources. Amy Besel, Mental Health Program Administrator, actively participated in these discussions, responding to all the Council's questions in a forthright manner.

The Council made the following conclusions:

- Acknowledged that both SAMSHA and MHD are in the process of changing the format and data collecting methodology for the Implementation Report;

- The 2007 Performance Indicators have been markedly revised to improve and home reporting capabilities of MHD, being more closely aligned with the National Outcome Measure language required of SAMHSA, thus noting this is somewhat of a transition year;

- MHD was to be congratulated for meeting the overall Objectives and for setting challenging target/estimates that were high based on the present data system;

- Dr. Judy Hall, MHD, is working with SAMSHA and the Council to develop a more rapid and thorough data reporting system and to standardize the RSN data gathering, which will improve timeliness and accuracy;

- Council noted that some of the operational terms were "very sloppy" both at the federal and RSN levels which impedes meaningful measurement: and,

- On-going (3 years) Council concern for the legislatively mandated use of MHBG monies
  on the Mentally Ill Offender Unit based in Seattle.

In order to increase the Council's understanding and ability to give early and on-going input into the final 2007 Implementation Report, the Council voted on and initiated an Annual Project at the October 2006 meeting. The timeline for this Project is as follows:

- November 2006 - each "population focused" Subcommittee (i.e. Children's, Adult Consumers, Older Adults, Sexual Minorities and Ethnic Minorities) will receive the MHBG/RSN contracts and the MHD/MHBG budget;

- January 2007 -Each "population focused" Subcommittee will determine whether to monitor sections relevant to their populations and inform the Council.

- March 2007 - Council will compare signed RSN contracts and MHD's budget to check for viability and accountability to meeting contractual obligations and utilization guidelines;

- October 2007- Council will compare signed RSN contracts and MHD's budget for MHBG monies to actual performance as reflected in the 2007 Implementation Report sent to the feds in November.

It should also be noted that 2 members of the MHPAC were involved of pre-contract review of the RSN MHBG planned use of 20076 funds. The above Annual Project is seen as a next step to this in an effort to increase the Council's oversight and detailed

knowledge of MHBG expenditures and performance.

In the past, the Council has reviewed MHD's Performance Indicator Report on an annual basis. In 2006, the Council reviewed it and then had a second meeting to discuss specific concerns. In 2007, the Council plans to have at least three meetings on this topic. Three Council members are actively involved with the Performance Indicator Work Group.

The Council is totally committed to meeting its federal mandate and Council duty "to review the Mental Health Block Grant Plan and to make recommendations". The Council would like to thank John Morrow in your office and Amy Besel in our MHD's office for their diligence and highly informative participation in this process.

Sincerely,

(Signature on file)

Joann Freimund, Chair

cc: Richard E. Kellogg, Director, Mental Health Division
Amy Besel, MHBG State Planner

V. Performance Indicators:

CRITERION 1: Comprehensive Community-Based Mental Health Plan

Goal 1 Increase Access to Services - Adult

Individuals have access to a system of comprehensive and integrated community based services.

Objective 1: Increase access to services for adults

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 1.5 % for adults who received publicly funded outpatient mental health services**. (Basic Table 2a)**

2002: 2.1 % (Achieved)
2003: 2.2% (Achieved)
2004: 2.1% (Achieved) 79,300/3,687,492 = 2.2%
2005: 2.1% (Achieved) 76,309/3,687,492 = 2.1%
2006: 2.3% (Not Achieved) 73,466/ 3,687,492 = 2.0%

Narrative: The overall Performance Indicator of maintaining a penetration rate of at least 1.5% was achieved, however, the estimated target for 2006 of 2.3% was not. Washington is continuing to experience decreased penetration rates, estimated to be the result of insufficient resources secondary to the loss of the ability to use Medicaid Savings for services to non-Medicaid individuals. This is despite the legislature's increased support given in an effort to mitigate the system's losses.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Sound RSN** used MHBG funds to Community support services for persons who were not eligible for the Medicaid program. Services promoted recovery and resiliency by assisting low income clients who were in acute care settings, or were at risk of hospitalization, incarceration, or recurrent crisis episodes.
- **Thurston Mason RSN** used MHBG funds to provide crisis intervention and triage services to non-Medicaid persons in an effort to avoid hospitalization or incarceration.
- **Greater Columbia RSN** used MHBG funds to support and crisis intervention services to non-Medicaid persons, facilitating transition to ongoing community MH services whenever possible.
- **Clark County RSN** used MHBG funds to provide individual treatment services to consumers who were not eligible for Medicaid through a program called Wellness Project.
- **North Central RSN** used MHBG funds to provide individual treatment services to consumers who were not eligible to Medicaid. It also supported use of funds to help obtain housing, purchase medications and food for persons who were in transition from an institution or another region.

- **Timberlands RSN** used MHBG funds to provide individual treatment services to consumers who were not eligible to Medicaid. It also supported use of funds to help obtain housing, purchase medications and food for persons who were in transition from an institution or another region.
- **Peninsula RSN** used MHBG funds to support the development and maintenance of community support activities for persons with serious mental illness or emotional disturbance who were not eligible for Medicaid. Supportive services, and flexible funds as needed, were provided to support crisis outreach and intervention activities for these persons as well.

Objective 2: Provide seamless discharge from inpatient services

***Performance Indicator*:** Regional Support Networks will maintain a percentage of clients over 30% who received outpatient services within 30 days after being discharged from the state hospital, community hospital, or freestanding evaluation and treatment facility.

2002: 45.9% (Achieved)
2003: 58.2% (Achieved)
2004: 55.8 % (Achieved) 8,409/13257 = 63.4%
2005: 55.8% (Achieved) 7,996/ 12,859 = 62.2%
2006: 55.5% (Planned) Not available at this time

Narrative: RSNs are required by contract with MHD to ensure that consumers are seen within 7 days of hospital discharge. The targeted goal has been consistently exceeded and modified in the 2007 Plan.

RSN Services: No RSN services/activities were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 3: Increase access to services for American Indians

Performance Indicator: Maintain a statewide penetration rate of at least 2% for American Indian persons who received publicly funded outpatient mental health services. **(Basic Table 2a)**

2002: 4.7% (Achieved)
2003: 3.9% (Achieved)
2004: 3.9 % (Achieved) 3,560 / 91,053 = 3.9%
2005: 3.7% (Achieved) 3,362 / 91,053 = 3.7%
2006: 4.5% (not Achieved) 3,170/91,053 = 3.5%

Narrative: The overall Performance Indicator of maintaining a statewide penetration rate of at least 2% was achieved; however the estimated target of 4.5% was not. MHD provides funding to support tribal and intertribal projects promoting culturally relevant and culturally accessible mental health activities for American Indians, Alaskan Natives, and their communities. RSNs are also required through contract with MHD to develop 701 plans with the tribes who reside within their RSN boundaries and are strongly encouraged to work collaboratively with them. Tribal engagement varies between RSNs and Tribes, with some RSNs reporting close relationships and others reporting minimal interaction. The 2006 target was too optimistic.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Sound RSN** used MHBG funds to support over 500 people participating in an innovative and culturally relevant program providing mental health treatment for American Indians from a holistic approach, healing the spiritual, physical, and emotional elements to restore balance to the person and the community in partnership with the Tulalip Tribe.

Objective 4: Increase access to services for ethnic minorities

Performance Indicator: Maintain a statewide penetration rate of at least 1.5% for ethnic minority persons who received publicly funded outpatient mental health services**. (Basic Table 2a)**

2002: 2.09% (Achieved)
2003: 2.1% (Achieved)
2004: 2.9 % (Achieved) 39,948/1,358,894 = 2.9%
2005: 2.8 % (Achieved) 38,280/1,358,894 = 2.8%
2006: 2.3 % (Achieved) 38,280/1,358,894 = 2.8%

Narrative: The Performance Indicator of maintaining a penetration rate of at least 1.5% was met. Further, the estimated target for 2006 of 2.3% was exceeded. MHD supports a variety of activities that promote cultural competency including conferences and specialist training. RSNs are required through contract with the MHD to ensure services provided are culturally competent across age, ethnicity, gender, etc.

Performance Indicator: The MHD will support an annual consumer forum to promote ethnic minority consumer involvement in systems change and to support research on promising practices and the delivery of effective community based services to ethnic minority populations.

2005: Achieved
2006: Achieved

Narrative: The Ethnic Minorities Forum was another success this year. The issues of ethnic minorities continue to gain momentum. The 2005 Annual Meeting of MHPAC was hosted by the ethnic Minority Sub-Committee of MHPAC. As such, education, recognition and interest in minority issues continue to grow and play an important role in enhancing the delivery of culturally competent services.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Sound RSN** used MHBG funds to the full array of MH services to persons of Hispanic origin who were not eligible for Medicaid. It also used MHBG funds to support the provision of a MH technician at a community medical clinic serving the same minority population.

Objective 5: Increase access to services for older adults

Performance Indicator: Regional Support Networks will maintain the proportion of older adults (60+ years) who received publicly funded outpatient mental health services at a rate greater than 1% of the general population. **(Basic Table 2a)**

2002: 1.4% (Achieved)
2003: 1.4% (Achieved)
2004: 1.3 % (Achieved) 12,856/957,899 = 1.3%
2005: 1.2 % (Achieved) 11,667/957,899 = 1.2%
2006: 1.5% (not Achieved) 10,837/957,899 = 1.1%

Narrative: The overall Performance Indicator of maintaining the proportion of older adults who received public MH services at least 1% greater than the general public was achieved; however the estimated target of 1.5% was not. Again, penetration rates in general appear to be declining secondary to funding and resource issues.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Sound RSN** used MHBG funds to provide case finding, engagement, mental health services, and referral services as appropriate for at-risk older adults and to provide evaluation, treatment, case review, psychiatric consulting, and prescription services to older adults not eligible for Medicaid.
- **North Central RSN** used MHBG funds to provide individual treatment services to older adults who were not eligible for Medicaid.
- **Timberlands RSN** used MHBG funds to support the Elder Support Team, a multi-agency, collaborative group that meets regularly to identify and resolve issues of care for older adults. The RSN also supported the Alzheimer Care Givers Support Group.
- **King County RSN** used MHBG funds to support Geriatric Crisis Services (GCS) providing specialized, out-of-facility crisis services to older adults not authorized to the Mental Health Plan outpatient program. Services are designed to resolve immediate crisis, provide stabilization in the location where the client is living; and provide referrals to appropriate services that are based on comprehensive assessments.

Objective 6: Support training on the specialized needs of older adults

Performance Indicator: The MHD will support conferences and trainings with at least 20 participants at each event on the specialized needs of older adults consistent with evidence-based practice approaches.

2005: Achieved
2006: Achieved

Narrative: MHD supported Older Adult Case Manager Academy training with MHBG funds in partnership with our sister agency in Health and Recovery Services Administration, the Division of Alcohol and Substance Abuse, to increase expertise at the

clinical level of the specialized needs of older-adults. Specific attention was given to OA's with substance abuse issues.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 7: Increase access to services for sexual minorities

Performance Indicator: Provide mental health services and programs to a minimum of 1,500 adults who identify as sexual minorities.

2004: 1,731 (Achieved)
2005: 2,166 (Achieved)
2006: 1,573 (Achieved)

Narrative: Addressing the unique needs of persons who self identify as Gay, Lesbian, Transgender, or Bi-sexual and the needs of their families, advocates, and supports is recognized by Washington State as an important part of meeting the mental health needs of the whole person. The annual Say It Out Loud Conference (co-sponsored by MHD and DASA) was attended this year by DSHS Secretary Robin Arnold Williams, which served as demonstrable support to this minority population. Removing the barriers of secrecy and stigmatization can only lead to greater understanding, equity, and stronger ***Recovery***. This year's MHPAC Annual Stakeholder's Meeting was hosted by the Sexual Minorities sub-committee of MHPAC. Reviews of the event gave high marks for added value and education.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Performance Indicator: The MHD will support an annual "Say It Out Loud" conference co-sponsored with the Division of Alcohol and Substance Abuse to increase sensitivity on sexual minority issues.

2005: Achieved
2006: Achieved

Narrative: See above narrative

Objective 8: Increase access to services for adults with a developmental disability

Performance Indicator: Serve at least 3,000 persons with both a mental illness and a developmental disability in outpatient settings. .

2002: 3,309 persons, or 2.5% of persons served (Achieved)
2003: 5,582 persons, or 4.4% of persons served (Achieved)
2004: 5,567 persons or 4.2 % of persons served (Achieved)
2005: 5,122 persons or 4.1 % of persons served (Achieved)
2006: 3,700 persons (Achieved) 4,947 persons or 4.1 % of persons served

Narrative: The overall Performance Indicator of serving at least 3,000 persons

with both a mental illness and a developmental disability was met. The specific target for 2006 was exceeded.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Performance Indicator: The MHD will provide cross-system training on persons with a developmental disability to promote a highly skilled workforce current with best practices.

2005: Achieved
2006: Achieved

Narrative: MHD partnered with the Division of Developmental Disabilities using MHBG funds to support a specialized training for Emergency Room doctors as well and floor staff in community hospitals to improve knowledge of MH/ DD issues.

Objective 9: Increase access to services for adults with a sensory impairment

Performance Indicator: Serve at least 1,000 persons with both a mental illness and a sensory impairment in outpatient settings.

2002: 1,662 or 1.3% of persons served (Achieved)
2003: 2,440 or 1.9% of persons served (Achieved)
2004: 2,645 or 3.3 % of persons serviced (Achieved)
2005: 2,386, or 1.9 % of persons serviced (Achieved)
2006: 2,550 (not Achieved) 2,040 or 1.7 % of persons serviced (Achieved)

Narrative: The overall Performance Indicator of serving at least 1,000 persons with both a mental illness and a sensory impairment was overwhelming met, however, the 2006 targeted goal was not.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 10: Increase access to medical services

Performance Indicator: Maintain a percentage of at least 70% of adult consumers who saw a nurse or doctor in the past year for a health check up or because they were sick.

2004: 88.9 %
2005: Not available at this time
2006: 89.3 % (Achieved)

Narrative: RSNs are expected through contract to address the medical and dental needs of consumers under enrolled in their service plan. Additionally, pilot programs have been implemented in two of the larger RSNs (King County and Pierce County) to further promote this practice. Whole person care is an important concept for

MHD and one that the RSNs are encouraged to embrace.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 11: Increase access to dental services

Performance Indicator: Regional Support Networks will provide assistance to adult and child consumers to obtain state and federal entitlements (e.g. Medicaid).

2005: Achieved
2006: Achieved

Narrative: As part of HB 1290 the MHD has partnered with the Economic Services Administration, Department of Corrections, the State Hospitals, and community Jails, and others to implement Expedited Eligibility discussed in detail on page 30.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Goal 2: Reduce Utilization of Psychiatric Inpatient Beds – Adult

Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings.

Objective 1: Reduce unnecessary hospitalization

Performance Indicator: Regional Support Networks will maintain a percentage of adult outpatient clients who were not hospitalized at a rate over 80%.

2002: 93.5% (Achieved)
2003: 93.5% (Achieved)
2004: 93.8 % (Achieved)
2005: 90.7 % (Achieved) 69,242/ 76,309 = 90.7%
2006: 94.0% (not Achieved) 69,909/ 73,466 = 91.1% (Achieved)

Narrative: The overall Performance Indicator of maintaining a rate over 80% of non-hospitalization was exceeded by nearly 10%, however the specific targeted goal for 2006 of 94.0% was overly optimistic. The STI related to Utilization Management is expected to continue inroads toward decreased reliance on hospitals in favor of earlier prevention, greater support, and Recovery in one's own community whenever a hospital level of care is not necessary.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **King County RSN** used MHBG funds to support Intensive Community Support Program (ICSP) identifying and serving patients whose treatment needs constitute substantial barriers to community placement. Services included pre-discharge planning, community transition support services, intensive housing supports, and community case management that

emphasize recovery and tenure in the community. The program provides wrap-around services that are individualized and tailored to each client's unique needs.

Performance Indicator: Maintain a utilization rate of under 25 days per 1,000 population for clients admitted to community hospitals and freestanding evaluation and treatment facilities.

2002: 22.1 days per 1,000 population (Achieved)
2003: 21.2 days per 1,000 population (Achieved)
2004: 21.6 days per 1,000 population (Achieved)
2005: 20.1 days per 1,000 population (Achieved)
2006: 21.0 days (not Achieved) 18.9 days per 1,000 population (Achieved)

Narrative: The overall Performance Indicator of maintaining a utilization rate under 25 days per 1,000 population for inpatient treatment was exceeded, however, the specific targeted goal for 2006 of 21.0 days was also exceeded and therefore not met.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Performance Indicator: Maintain a statewide rate of adults served in state hospitals not greater than 0.7 per 1,000 general population.

2002: 0.6 per 1,000 population (Achieved)
2003: 0.5 per 1,000 population (Achieved)
2004: 0.5 per 1,000 population (Achieved) 1,816/3,687,492 * 1,000 = 0.5
2005: 0.5 per 1,000 population (Achieved) 1,816/3,687,492 * 1,000 = 0.5
2006: 0.5 per 1,000 population (Achieved) 1,816/3,687,492 * 1,000 = 0.5

Narrative: As noted several places in this report, state hospital are an integral part of the continuum of care. As such, many issues that affect the community mental health system affect the hospital census and visa-versa. The STI focused on the development and implementation of 8 PACT teams is expected to have a positive impact on hospitalization rates as wards of the state hospitals will be closing with the start-up of each new PACT team.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 2: Reduce rate of readmission to inpatient services

Performance Indicator: Regional Support Networks will maintain a percentage of under 5% of clients who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were readmitted to any of the inpatient settings within 30 days

2002: 3.9% (Achieved) 801/10,966 = 7.3% (not Achieved)
2003: 3.2 % (Achieved) 760/10,444 = 7.3% (not Achieved)
2004: 2.8 % (Achieved) 766/10,140 = 7.5% (not Achieved)

2005: 2.8 % (Achieved) 769/9,793 = 7.9% (not Achieved)
2006: 3.8% (not Achieved) 457/7,738 = 5.9% (not Achieved)

Narrative: In reviewing the ever dynamic data, research staff discovered errors with the underlying data. Accordingly, all of the previously reported numbers and targets from which the data was set from 2002 were not in line with the identified Performance Indicator of maintaining a percentage under 5% for readmission within 30 days. Correct calculations for these years are in green. This Performance Indicator has been changed in the 2007 plan. While the re-admission rate overall seems to be improving the goals established up to now were apparently not within the scope of reason.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Performance Indicator: Regional Support Networks will maintain a proportion of persons served in community hospitals and freestanding evaluation and treatment facilities at a statewide rate not greater than 3.0 per 1,000 persons in the general population.

2002: 1.6 per 1,000 population (Achieved)
2003: 1.4 per 1,000 population (Achieved)
2004: 1.4 per 1,000 population (Achieved) 8,493/6,167,868 * 1,000 = 1.4
2005: 1.3 per 1,000 population (Achieved) 8,299/6,167,868 * 1,000 = 1.3
2006: 1.2 per 1,000 population (Achieved) 7,420/6,167,868 * 1,000 = 1.2

Narrative: RSNs are continually looking for ways to divert consumers from hospitalization when appropriate. Again the Utilization Management STI is one tool expected to be used in continuing to decrease unnecessary or extensive hospitalizations.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 3: Provide crisis intervention services

Performance Indicator: Regional Support Networks will provide crisis intervention services.

2005: Achieved
2006: Achieved

Narrative: MHD has allowed in the past for RSNs to utilize MHBG through contract for the provision of crisis services. However, as stated earlier, a policy shift has occurred this past year. Accordingly, this is no longer considered in and of itself a reasonable use of MHBG funds as each RSN receives funding through their state-only contract for crisis services. The 2007 MHBG Plan has been changed to reflect this.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North East RSN** used MHBG funds to Provide crisis services to non-Medicaid eligible consumers, stressing the use of stabilization resources as alternative to hospitalization when appropriate.
- **Thurston Mason RSN** used MHBG funds to provide crisis triaging services to persons who were not eligible for Medicaid to avoid hospitalization or incarceration.
- **Peninsula RSN** used MHBG funs to support the operations of its Crisis Outreach Team, providing crisis services and hospital diversion services to consumers who were not eligible for Medicaid.
- **Chelan Douglas RSN** used MHBG funds to increase the number of consumers receiving crisis triage residential services.
- **King County RSN** used MHBG funds to support Emergency Telephone Services, providing screening, assessments and referrals of consumers in crisis.
- **Spokane County RSN** used MHBG funds to support crisis intervention and hospital diversion services to consumers not eligible for Medicaid.

Objective 4: Develop residential alternatives to hospitalization

Performance Indicator: Regional Support Networks will provide services to at least 30% of their consumers in residential settings

2006: Not available at this time

Narrative: Data collection is delayed on this but will be submitted in next report.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Pierce County RSN** provided Crisis Triage residential services as an alternative to hospitalization.

Goal 3: Implement Evidence-Based Practices

Implement Evidence Based Care statewide, to include reporting guidelines, fidelity assessments, incentives, increased monitoring of consumer outcomes, process for incorporation of new Evidence Based Practices.

Objective 1: Develop best practice resource guides

Performance Indicator: The MHD will support development of Resource Guides and disseminate no fewer than 100 EBP Resource Guides in an effort to share information on evidence-based best practice models for engaging and serving mental health consumers.

2005: Not available at this time
2006: 125 (Achieved)

Narrative: As mentioned above, EBP research and implementation is highly valued by Washington State. As a second step to the Resource Guides, MHD has contracted for an EBP Provider Survey found in Attachment A of this report.

RSN Services: No RSN services were directly supported with MHBG funds

related to this Criterion, Goal, Objective:

Objective 2: Conduct research on emerging/promising practices

Performance Indicator: The MHD will support research on selected promising practices to support effective community based services and promote evidence-based practice.

2005: Achieved

Narrative: (Please see narrative above)

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 3: Support an annual statewide Behavioral Healthcare Conference

Performance Indicator: The MHD will provide support to the annual Behavioral Health Conference to promote a highly skilled workforce current with best practices including scholarships for consumers, parents and family advocates as evidenced by providing no fewer than 15 scholarships to these persons.

2005: 18 (Achieved)
2006: 150 (Achieved)

Narrative: This year's conference was heralded by some as the "best one yet" with credit being given to this through the increase, by nearly ten-fold, in the number of consumer scholarships made available. The RSNs partnered in meeting the call for greater consumer participation by providing assistance with travel and per diem expenses. Collaboratively, this was a well supported endeavor and is budgeted to occur at this same level again in 2007.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 4: Provide training for consumers and family advocates

Performance Indicator: MHD will instigate a Request for Proposal (RFP) and contract with selected entities to provide at least 4 trainings this year to consumers and their family members.

2006: 4 trainings (Achieved)

Narrative: Trainings have been conducted; however, an RFP process was not utilized, rather contracting occurred through smaller conferences, and trainings. Most exciting was two Dad's retreat one in February and another in August. The February retreat had 17 registered and the August had 22 registered. The Dad's focused on such topics as transition to adulthood, school issues, the evolution of public mental health, and the direction or need for forming a more "formal organization". A major development and change from the February to August change was the involvement of the Dads in the planning and facilitation of the August meeting. They took over not only the agenda, but

the cooking, and team building exercises. As of this writing, they have developed a web page for ongoing communication and are busily planning their next retreat including looking for a larger facility so more dads may attend.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 5: Provide training for case managers and mental health professionals.

Performance Indicator: The MHD will conduct training for case managers and mental health professionals, focusing evidence-based and promising practice models of service delivery.

2005: 30 (Achieved) CM's or MHP's trained
2006: 30 (Achieved) CM's or MHP's trained

Narrative: This training occurs through contract with WIMIRT as well as the RSNs.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Central RSN** used MHBG funds to provide training to CMs on rural COD issues and evidence based practice. It also used funds to train 20 Masters level clinician in EMDR for treatment in PTSD.
- **Spokane RSN** used MHBG funds to support the activities of the Camas Institute through the Kalispel Tribe, recruiting MHPs and gateway professionals, contracting trainers, coordinating training, and training needs, providing training space (on site, down-link video conferencing) and environment for C/Ms and MHPs with a focus on evidenced based practices for the purpose of creating an increased network of resources and increased positive outcomes for consumers. Total training hours equaled 640.

Objective 6: Provide Mental Health Specialist training

Performance Indicator: The MHD will conduct training for mental health specialists, focusing evidence-based and promising practice models of service delivery.

2005: 20 (Achieved) MH Specialists trained
2006: 20 (Achieved) MH Specialists trained

Narrative: This training occurs through contract with WIMIRT as well as the RSNs. RSNs are required through contract and Washington Administrative Code (WAC) to provide culturally competent services.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Spokane County RSN** used MHBG funds to support the Camas Institute

through the Kalispel Tribe for the purposed of recruiting MHPs and gateway professionals, contracting with trainers, providing and coordinating per person the 100 hours (specific to ethnic minority) of specialized training in how to effectively deliver culturally and linguistically appropriate evidenced based services including but not limited to assessment, diagnosis, treatment and data collection. Total training hours equaled 2,000.

Objective 7: Develop and support the use of Assertive Community Treatment

Performance Indicator: Number of persons receiving Assertive Community Treatment (ACT) Services. **(Developmental Table 17)**

2005: Not available at this time
2006: 2,371 (Achieved)

Narrative: As identified several places in this report, the legislature has provided funding to start-up 8 PACT teams state-wide, which is expected to have far-reaching outcomes. This data has been collected through the EBP Provider Survey.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 8: Develop and support the use of Family PsychoEducation

Performance Indicator: Number of persons receiving Multi-Family PsychoEducation Programs as part of an overall clinical treatment plan for individuals with mental illness. **(Developmental Table 17)**

2005: Not available at this time
2006: 1,913 (Achieved)

Narrative: This data has been collected through the EBP Provider Survey which will serve as a baseline for further assessment and development.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 9: Develop and support the use of Illness Self-Management Skills

Performance Indicator: Number of persons receiving a broad range of self-assessment and treatment skills to assist persons with a mental illness and their caregivers to assist consumers to be able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. **(Developmental Table 17)**

2005: Not available at this time
2006: 14,412 (Achieved)

Narrative: This data has been collected through the EBP Provider Survey which

will serve as a baseline for further assessment and development.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Pierce County RSN** used MHBG funds to support an illness education program called Pebbles In The Pond.

Objective 10: Develop and support the use of Dialectical Behavior Therapy

Performance Indicator: Number of community mental health agencies implementing Dialectical Behavior Therapy (DBT) Programs.

2006: not Achieved

Narrative: This was originally expected to be included in the EBP Provider Survey, however, since it was not one of the SAMHSA identified EBPs, it was not measured. Though, as noted below, it was DBT services have been supported with MHBG funds.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Central RSN** used MHBG funds to support Dialectical Behavior Therapy Team development and delivery of direct clinical services to non-Medicaid consumers.

Goal 4: Improve Client Perception of Care - Adult

Individual choice, satisfaction, safety, and positive outcomes are the focus of services.

Objective 1: Promote consumer satisfaction in service delivery

Performance Indicator: More than fifty percent of adults surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year.* **(Basic Table 11)**

2002: 77.1% (Achieved)
2003: Not available
2004: 76.7 % (Achieved)
2005: Not available
2006: 78.0 % (Planned) 79.2% (Achieved)

Narrative: The Performance Indicator of maintaining more that fifty percent was clearly exceeded, as was the individual target for 2006. This goal has been changed in the 2007 Plan to more closely reflect expected goals.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Goal 5: Increase in Employment or Return to School - Adult

Support consumer recovery through employment and supported employment opportunities.

Objective 1: Increase consumer employment

Performance Indicator: Regional Support Networks will maintain a statewide percentage of at least 10% of adult outpatient service recipients between the ages of 18 and 64 years who were employed at any time during the fiscal year. (**Basic Table 4)**

2002: 13.0% (Achieved)
2003: 11.5% (Achieved)
2004: 11.5 % (Achieved) 9,440/ 82,422 = 11.5%
2005: 10.8% (Achieved) 8,620/ 79,524 = 10.8%
2006: 12.0% (not Achieved) 8,057/ 76,627 = 10.5%

Narrative: The Performance Indicator of RSNs maintaining at least a 10% employment rate was achieved; however the 2006 target of 12.0% was too ambitious. Employment opportunities and sufficient support have long been lacking for persons with psychiatric disabilities in Washington. As mentioned earlier, however, MHD is rededicating its resources toward this area. In fact, out of the planned use of MHD's portion of MHBG funds expected in 2007, MHD is increasing the funding on Employment from 20K to 250K and is seeking input from MHPAC and others on ways in which to infuse the system with services related to employment. MHD also encourages the creation of ICCD Club Houses geared toward the same outcomes.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **King County RSN** used MHBG funds to support Regional Employment Services & Placement Center (RESPC) developed to assist clients to achieve a better standard of living, increased involvement in the communities in which they live, and enhanced self-esteem and work with regional and local Division of Vocational Rehabilitation (DVR) offices, work force development systems, and the King County mental health system to increase number of consumers employed. Nearly 200 consumers are served annually.

Objective 2: Support consumer education opportunities

Performance Indicator: Regional Support Networks will provide supported education opportunities for a minimum of 20 consumers.

2005: 20 Consumers (Achieved)
2006: 20 Consumers (Achieved)

Narrative: Educational opportunities and supported education are strongly endorsed by MHD, however, like other states we are struggling with the realization that funding resources are limited. RSNs are encouraged to work at the local level to foster these opportunities. At the same time, MHD is investigating potential partnerships with

institutions of higher learning.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Peirce County RSN** used MHBG to serve approximately 70 consumers participating in a supported education program with a local community college.

Objective 3: Provide supported employment for consumers

Performance Indicator: Regional Support Networks will provide supported employment to at least 500 consumers. **(Developmental Table 17)**

2002: 784 or 0.6% of persons served (Achieved)
2003: 620, or 0.5% of persons served (Achieved)
2004: 1,233, or 0.9% of persons served (Achieved)
2005: 1,025 or 0.8% of persons served (Achieved)
2006: Not available at this time

Narrative: Data collection on this is unavoidably delayed but will be included in next report.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Chelan Douglas RSN** used MHBG funds to support transitional employment efforts at clubhouse resulting in 10 placements.

Performance Indicator: Supported employment opportunities in state government will be provided to a minimum of 6 consumers.

2002: 12 (Achieved)
2003: 12 (Achieved)
2004: 12 (Achieved)
2005: 12 (Achieved)
2006: 12 (Achieved)

Narrative: Washington has continued to maintain the current levels of supported employment in state government, though unfortunately, there has been no forward movement in increasing these numbers.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

GOAL 6: Decrease Criminal Justice Involvement - Adult

Expand cross-system care coordination efforts within DSHS and the Department of Corrections and other relevant agencies.

Objective 1: Decrease adult criminal justice involvement

Performance Indicator: Number of adults with a mental illness who had contact with the criminal justice system including arrest and incarceration. **(Developmental Table 19A)**

2003: 20.3% (Achieved) 25,947/127,519 = 20.3%
2004: Not available at this time
2005: Not available at this time
2006: Not available at this time

Narrative: Data collection for this Performance Indicator is quite complicated and requires information from other sources with significant delay. For example FY 05 data won't be available to MHD until 2007. Last year MHD reported FY 03 data for our DIG tables. We expect to have FY 04 by mid-December.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Central RSN** used MHBG funds to develop a Mental Health Court in its region expanding its working relationship with the offices of County Prosecuting Attorney, Public Defender, Superior Court and DOC.

Objective 2: Provide services to consumers released from the criminal justice system

Performance Indicator: Regional Support Networks will provide community mental health and other supportive services to assist consumers who have been released from the criminal justice system to successfully transition back into the community.

2005: Achieved
2006: Achieved

Narrative: Transitional services for persons with mental illness who are incarcerated have increased dramatically over the last year as indicated in Section II of this report. These transitional services, required by contract, have been paired with expedited determinations of Medicaid, resulting in increased access to MH services.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **King County RSN** provided services to support mentally ill offenders being released from state prisons in making a successful transition to the community.

Goal 7: Increase Social Supports - Adult

Support consumer clubhouses, implement peer support programs and certify Peer Counselors.

Objective 1: Support consumer clubhouses and drop-in centers

Performance Indicator: Regional Support Networks will provide support for consumer clubhouses and drop-in centers.

2005: Achieved
2006: Achieved

Narrative: RSNs are encouraged to develop ICCD Club Houses and training on how to go about creating such services has been supported by MHD with MHBG funding. Several RSNs have operated drop-in centers, however, greater focus is currently being given to development of the club house model in an effort to impact employment.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Clark County RSN** used MHBG funds to maintain a consumer-run warm line operation and drop-in center called Consumer Voices Are Born. Funds were also used to obtain consultation and training on how to set-up an ICCD Club House.
- **Spokane County RSN** used MHBG funds to support the Evergreen Club which is an ICCD Club House.

Objective 2: Increase the number of peer support counselors

Performance Indicator: MHD will provide specialized training to consumers resulting in the certification of at least 10 new peer support counselors.

2006: 10 (Achieved)

Narrative: The role of Peer Counselors continues to grow as do the number of Peer Counselors trained. MHD provides MHBG funding for training and testing through an approved curriculum which is facilitated through contract with WIMIRT. MHD is currently evaluating allowing other entities to provide this training.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 3: Support the consumer Ombuds function

Performance Indicator: The MHD will provide training and support to RSN consumer Ombuds members.

2005: Achieved
2006: Achieved

Narrative: This training is ongoing with 2-4 training sessions per year and is provided through contract with WIMIRT. RSNs are required in contract to ensure the availability of independent Ombuds services.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 8: Increase Family Stabilization/Living Conditions - Adult

Services promote independent living through natural and community supports including

family, friends, and other citizens.

Objective 1: Provide support for independent living arrangements

Performance Indicator: Maintain a statewide percentage of at least 60 % of adults and older adults who had an independent living situation as their primary residence at any time during the fiscal year.

2002: 56.3% (Achieved)
2003: 64.5% (Achieved)
2004: 63.8 % (Achieved) 58,706/92,214 = 63.8%
2005: 64.4% (Achieved) 56,817/88,291 = 64.4%
2006: 65.0% (not Achieved) 53,846/ 84,471 = 63.7%

Narrative: The overall Performance Indicator of maintaining a state wide average of at least 60 % of adults and older adults who had an independent living situation as their primary residence at any time during the fiscal year was exceeded, however the 2006 target of 65% was in keeping with the predicted trend which did not bear out as anticipated. The measure this objective has been changed in the 2007 Plan to improve accuracy in meeting our goals.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Support consumer and family advocacy activities

Performance Indicator: Support consumer and family advocacy self-help, social activities, pre-vocational skill building and stigma reduction activities, which may also include funding to attend conferences, training and other mental health resource activities.

2005: Achieved
2006: Achieved

Narrative: This year, five parents and youth attended the Federation of Families conference where they presented a timeline of parent activities with the state mental health staff.

Another four parents attended the Training Institutes in Florida and came back and shared what they learned at the statewide Community Connector's training. The two youth attended through the SAFE-WA contract and were presenters at the conference. Another outcome of this training was that one of the dads made a connection with the dads group from Georgetown and continues to be excited about the possible connections and support for dads in Washington State.

Through the contract with SAFE-WA, an additional six parents attended these two events.

Parents also received scholarships to attend the Washington Behavioral Health Conference.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Pierce County RSN** used MHBG funds to support operation of its consumer-operated Resource Center.

- **Clark County RSN** used MHBG funds to contract with the local affiliate of the National Alliance for the Mentally Ill (NAMI) to provide education of consumers, families and the community based on the Crisis Intervention Team (CIT) training. MHBG funds were also used by the RSN to provide scholarships to consumers, families, Quality Review Team, and Mental Health Advisory Board to attend trainings, workshops, and/or conferences

Goal 9: Adults with Co-Occurring Substance Use Disorders

Improve the delivery of services through an integrated approach to effectively respond to the special needs of adults with dual diagnoses.

Objective 1: Improve services to adults with Co-Occurring Disorders

Performance Indicator: Maintain a statewide percentage of mental health outpatient service recipients who had both a mental illness diagnosis and a substance abuse diagnosis and/or substance abuse impairment at a rate of at least 5%.

2002: 14.6% (Achieved)
2003: 15.4% (Achieved)
2004: 15.9 % (Achieved)
2005: 17.3% (Achieved) 21,834/125,944 = 17.3%
2006: 14.0% (Achieved) 18,771/120,690 = 15.6%

Narrative: The 2006 target for this goal was exceeded by 1.6%. The Performance Indicator was exceeded by three times the estimated percentage. COD services remain a high priority for Washington, demonstrated through legislative direction and support as well as through collaborative partnership between MHD and DASA.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Central RSN** used MHBG funds to expand transition services to participants in Okanogan Drug Court, Mental Health Court and Chemical Dependency Treatment for non-Medicaid consumers with Co-Occurring Disorders.

Performance Indicator: Maintain a percentage of at least 3% of mental health outpatient service recipients who also received services from the DSHS Division of Alcohol and Substance Abuse.

2002: 10.5% (Achieved)
2003: 10.4% (Achieved)

2004: 11.0% (Achieved)
2005: 11.0% (Achieved) 14,409/130,703 = 11.0%
2006: 10.6 5% (Planned) not available at this time

Narrative: Please see narrative above.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: Maintain a percentage of at least 5% American Indian mental health outpatient service recipients who also received services from the DSHS Division of Alcohol and Substance Abuse.

2002: 9.4% (Achieved)
2003: 16.0% (Achieved)
2004: 12.1% (Achieved) 476/ 3,947 = 12.1%
2005: 12.3% (Achieved) 465/ 3,792 = 12.3%
2006: 11.0 % (Planned) not available at this time

Narrative: Tribal members struggling with substance abuse have improved access to treatment through MHD's sister agency DASA. The targeted goals consistently exceed this performance indicator, which has been changed for our 2007 Plan.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Provide integrated treatment for Co-Occurring Disorders

Performance Indicator: Regional Support Networks will provide dual diagnosis treatment for mental health and substance abuse interventions at the level of the clinical encounter. **(Developmental Table 17)**

2006: Achieved

Narrative: According to information gathered through our Provider Survey, 2,800 Consumers have been supported with dual diagnosis treatment for mental health and substance abuse.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Grays Harbor RSN** used MHBG funds to provide short-term mental health stabilization crisis residential beds and detoxification residential beds to non-Medicaid individuals who have co-occurring mental health and substance abuse issues.
- **North Central RSN** used MHBG funds to provide Primary medical "Health Screenings" to non-Medicaid consumers with Co-Occurring Disorders.
- **Peninsula RSN** used MHBG funds to provide integrated mental health and substance abuse treatment services to adults with co-occurring disorders through joint staffing, integrated chart reviews, and by

strengthening cross system coordination.

- **Southwest RSN** used MHBG funds to provide integrated mental health/substance abuse treatment services to non-Medicaid consumers with co-occurring substance abuse disorders through joint staffing, specialist oversight and cross system coordination.
- **Spokane County RSN** used MHBG funds to provide support services such as individual therapy, medication management, community outreach, group therapy, family therapy, and case management for consumers with co-occurring mental health and substance abuse disorders who are not eligible for Medicaid.

Objective 3: Support training on Co-Occurring Disorders

Performance Indicator: The MHD will jointly fund, plan, organize and offer annual co-occurring disorders conference with the Division of Alcohol and Substance Abuse to promote a highly skilled workforce current with best practices.

2005: Achieved
2006: Achieved

Narrative: The Annual Co-Occurring Disorders Conference was highly successful this year again, with participants receiving specialized training on issues of co-morbidity related to mental illness and substance abuse. Goals of the conference included enhancing clinical skills as well as promoting resource development and coordination**.** The conference was also attended by Secretary Robin Arnold Williams.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Criterion 2: Mental Health System Data Epidemiology

This criterion provides an estimate of Washington State data on the incidence and prevalence of serious mental illness among adults and serious emotional disturbance among children and quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Adults (18 years and older)

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121 Washington State has an estimated 194,686 adults with serious mental illness (SMI). The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of clients in our service population who have SMI. The MHD operationalized the guidelines using diagnoses and the Global Assessment of Functioning (GAF). All diagnoses except substance abuse, development disorders, personality disorders, and dementia were used in the calculation. A GAF score of 60 or below was used as the functioning cutoff to determine SMI status. All numbers reported are based on data from fiscal year 2005.

Table 1: SMI Estimates for Adults (18 years or older)

Estimated SMI	Total Adults Served	Estimated SMI Served	Quantitative Target
256,030	88,291	59,259	50,000

Children (0-17 years)

Based on the prevalence estimates provided by SAMHSA in the Federal Register, Vol. 64, No. 121 Washington State has an estimated number of children with serious emotional disorders (SED) between 77,426 and 92,911. The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of children in our service populations who have SED. The MHD operationalized the guidelines using diagnoses and the Children's Global Assessment Scale (CGAS). All diagnoses except substance abuse and development disorders were used in the calculation. A CGAS score of 60 or below was used as the functioning cutoff to determine SED status. All reported numbers are based on data from fiscal year 2005.

Table 2: SED Estimates for Children (0-17 years of age)

Estimated SED	Total Children Served	Estimated SED Served	Quantitative Target
77,426-92,911	37,956	24,407	20,000

CRITERION 3: Child Mental Health Plan

Goal 1: Increase Access to Services – Children and Youth

Individuals have access to a system of comprehensive and integrated community based services.

Objective 1: Provide community support services for children and youth

Performance Indicator: Regional Support Networks will maintain a percentage of at least 1% of children in the general population who received mental health services. **(URS Table 2a)**

2002: 2.4% (Achieved)
2003: 2.5% (achieved)
2004: 2.6% (Achieved) 38,929/1,522,477 = 2.6%
2005: 2.5% (Achieved) 37,546/1,522,477 = 2.5%
2006: 2.6% (not Achieved) 36,005/1,522,477 = 2.4%

Narrative: The overall Performance Indicator is consistently exceeded related to maintaining a percentage of at least 1% of children in the general population who received mental health services. The specific target of 2.6% for 2006 was a little generous by two-tenths of a percent.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Assure seamless discharge from inpatient services

***Performance Indicator*:** Regional Support Networks will maintain a percentage over 30% of children and youth who received outpatient services within 7 days after being discharged from an inpatient setting.

2002: 38.1% (Achieved)
2003: 46.7% (Achieved)
2004: 59.3% (Achieved)
2005: 50.1% (Achieved) 298/595 = 50.1%
2006: 47% (Planned) not available at this time

Narrative: RSNs are required through contract to promote a seamless discharge from inpatient services, though the issue of adequate community resources is sometimes limiting. The continued efforts of the Children's Mental Health Initiative are expected to build a stronger service base, thereby impacting the entire continuum of children's services.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Sound RSN** used MHBG funds to provide over 500 hours of

service to children and youth who were not eligible for the Medicaid by assisting low income kids who were in inpatient or other acute care settings to transition to outpatient services.

***Performance Indicator*:** Regional Support Networks will maintain a percentage over 40% of children and youth who received outpatient services within 30 days after being discharged from an inpatient setting.

2002: 49.2% (Achieved)
2003: 57.4% (Achieved)
2004: 73.3% (Achieved)
2005: 66.4% (Achieved) 395/595 = 66.4%
2006: 56.5% (Planned) not available at this time

Narrative: Please see narrative above.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 3: Improve access to services for ethnic minority children and youth

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 25% for ethnic minority children who received publicly funded outpatient mental health services. **(Basic Tables 2a and b)**

2002: 34.6% (Achieved)
2003: 35.5 % (Achieved)
2004: 36.7 % (Achieved)
2005: 33.7% (Achieved) 12,653/37,546 = 33.7%
2006: 35.5% (Achieved) 12,868/36,005 = 35.7%

Narrative: Both the overall Performance Indicator and the target for 2006 were exceeded. Providing culturally competent care to all our citizens is a priority for Washington's mental health system.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 4: Improve access to services for American Indian children and youth

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 3.5% for American Indian children and youth who received publicly funded outpatient mental health services. **(Basic Table 2a and b)**

2002: 4.1 % (Achieved)
2003: 3.8% (Achieved)
2004: 3.6% (Achieved) 1,391/ 33,518 = 4.2%
2005: 3.9% (Achieved) 1,307/ 33,518 = 3.9%
2006: 4.1% (not Achieved) 1,198/ 33,518 = 3.6%

Narrative: RSNs have continued to exceed this Performance Indicator, maintaining a penetration rate of at least 3.5% for American Indian children and youth who received publicly funded outpatient mental health services; however, the targeted goal of 4.1% was not attained, with final data reflecting 3.6%.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 5: Improve access to services for sexual minority youth

Performance Indicator: Regional Support Networks will provide mental health services and programs to more than 75 sexual minority youth.

2004: 132 (Achieved)
2005: 180 (Achieved)
2006: 200 (Achieved)

Narrative: Issues related to gender and sexual identities in youth are of concern to Washington as is resource development to better serve this minority. At the recent MHPAC Annual Stakeholders Meeting, one such resource was presented called Camp 10 Trees, which is a camp dedicated to children and youth who have GLTB issues or who are being raised in a family with such diversity. It is hoped that through sharing of this kind of resource that more will be created to address the unique and not-so-unique needs of these youths.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 2: Reduce Utilization of Psychiatric Inpatient Beds - Children

Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings.

Objective 1: Increase community-based services

Performance Indicator: Regional Support Networks will maintain a percentage of outpatient children and youth who were not hospitalized at a rate over 80%.

2002: 97.2% (Achieved)
2003: 97.6% (Achieved)
2004: 97.9% (Achieved)
2005: 97.8% (Achieved) 36,727/ 37,546 = 97.8%
2006: 98.0% (Achieved) 35,319/ 36,005 = 98.1%

Narrative: Both the Performance Indicator and the target for 2006 were exceeded in this goal, with fewer than 10% of children and youths served requiring hospitalization.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: Regional Support Networks will maintain a utilization rate of under 20 days per 1,000 population for children and youth admitted to a community inpatient setting.

2002: 13.3 days 1,000 population (Achieved)
2003: 12.7 days 1,000 population (Achieved)
2004: 12.5 days 1,000 population (Achieved)
2005: 12.4 days 1,000 population (Achieved)
2006: 13.1 days per 1,000 population (Achieved) 9.9 days per 1,000 population

Narrative: The Performance Indicator and targets for this goal have been consistently exceeded by nearly 50%.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: Regional Support Networks will maintain a statewide utilization rate for children and youth served in a state hospital or long-term inpatient programs at a rate that is not greater than 30 per 1,000 general population.

2002: 24.3 per 1,000 population (Achieved)
2003: 24.5 per 1,000 population (Achieved)
2004: 22.9 per 1,000 population (Achieved)
2005: 24.6 per 1,000 population (Achieved) 37,412/1,522,477 * 1,000 = 24.7%
2006: 23.5 per 1,000 population (Achieved) 29,8000/ 522,477 * 1000 = 19.6%

Narrative: The Performance Indicator and targets for this goal have been consistently exceeded each year.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Provide crisis intervention services

Performance Indicator: Regional Support Networks will provide crisis intervention programs for children and youth as an alternative to inpatient services.

2005: Achieved
2006: Achieved

Narrative: MHD has allowed in the past for RSNs to utilize MHBG through contract for the provision of crisis services. However, as stated earlier, a policy shift has occurred this past year. Accordingly, this is no longer considered in and of itself a reasonable use of MHBG funds as each RSN receives funding through their state-only contract for crisis services. The 2007 MHBG Plan has been changed to reflect this.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **King County RSN** used MHBG funds to support Children's Crisis Outreach Response System (CCORS) which serves children or youth in King County aged three through 17 years that are not authorized to the Mental Health Plan outpatient program, providing access to crisis stabilization services, promoting strengths and skill building for caregivers and youth and maintaining children and youth in their home or current living arrangement. This program responds to at least 600 referrals per year an average response time of less than 2 hours.

Objective 3: Decrease rate of readmission to inpatient services

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: Regional Support Networks will maintain a percentage under **10%** of children and youth who were discharged from an inpatient setting, and who were readmitted to an inpatient setting within 30 days.

2002: 8.0 % (Achieved)
2003: 9.1 % (Achieved)
2004: 7.9 % (Achieved)
2005: 6.9% (Achieved) 35/ 508 = 6.9%
2006: 10.0% (Planned) Not available at this time

Narrative: The Performance Measure for this Objective has been consistently exceeded. The measurement for this objective has been changed in the 2007 MHBG Plan to reflect SAMSHA's request for an actual count verses percentages.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: Regional Support Networks will maintain a proportion of children and youth served in state hospital or CLIP settings at a statewide rate not greater than 0.5 per 1,000 persons in the general population.

2002: 0.1 per 1,000 population (Achieved)
2003: 0.1 per 1,000 population (Achieved)
2004: 0.2 per 1,000 population (Achieved) 234/1,522,477 * 1,000
2005: 0.1 per 1,000 population (Achieved) 202/1,522,477 * 1,000
2006: 0.1 per 1,000 population (Achieved) 193/1,522,477 * 1,000

Narrative: Considerable energy and discussion has gone into assessing the CLIP services within the children/youth continuum of care this past year. MHD has historically contracted out the administration of this service, but is bringing it back into the role of headquarters with the new re-organization of MHD. Though CLIP has previously operated well under the Contractor, it is thought that improvements may be made in the service delivery system in closer coordination with related MHD headquarter activities. Another change over the past year came in removing the CLIP contracts from

the RSN contracts, and in MHD contracting directly with the facilities. This has decreased administrative burden for the RSNs and freed-up funding that was otherwise used to cover these administrative costs.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 3: Implement Evidence-Based Practices – Children/Youth

Implement Evidence Based Care statewide, to include reporting guidelines, fidelity assessments, incentives, increased monitoring of consumer outcomes, process for incorporation of new Evidence Based Practices.

Objective 1: Develop and support the use of a WrapAround Process

Performance Indicator: Number of children and youth served through a WrapAround process.

2006: (Planned) Unavailable at this time

Narrative: This measure was expected to be obtained from the EBP Provider Survey, how as it was not one of the SAMHSA identified EBPs, it was later excluded from the questionnaire. Other avenues of measure are being considered.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Develop and support the use of Multi-System Therapy

Performance Indicator: Community mental health agencies will provide Multi-System Therapy programs. **(Developmental Table 17)**

2006: Achieved

Narrative: Multi-system Therapy is considered a valuable EBP in working with children and youth and is provided to over 400 consumers and their families.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 3: Develop and support the use of Therapeutic Foster Care

Performance Indicator: Number of children and youth served in therapeutic foster care programs. **(Developmental Table 17)**

2006: Achieved

Narrative: Therapeutic Foster Care is considered a valuable EBP in working with children and youth and is provided to over 200 consumers and their families.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: The MHD will plan and co-fund the annual Foster Care Conference to provide information on therapeutic foster care mental health services.

2005: Achieved
2006: Achieved

Narrative: The annual Foster Care conference is sponsored largely by the Children's Administration, with support from MHD. Last year over 200 people participated in this valued event.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 4: Develop and support the use of Dialectical Behavior Therapy

Performance Indicator: Community mental health agencies will implement Dialectical Behavior Therapy (DBT) Programs.

2006: Achieved

Narrative: This was initially expected to be a measure in the EBP Provider Survey, but was later withdrawn so accurate counts statewide can not be given, however, through MHBG contracting; MHD is knowledgeable that DBT implementation is occurring.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Central RSN** used MHBG funds to support Dialectical Behavior Therapy Team development and delivery of direct clinical services to non-Medicaid consumers.

Objective 5: Increase Parent Support and Empowerment activities

Performance Indicator: The MHD will support training, meetings, and special projects of the Statewide Action for Family Empowerment of Washington (SAFE-WA), Community Connectors, and other activities to improve parent support and empowerment.

2005: Achieved
2006: Achieved

Narrative: This valuable organization has been supported by the Mental Health Division through MHBG funds, was the recipient of a SAMHSA grant in 2001, and has recently received its 501(c) 3 status. SAFE-WA is comprised of eleven family-driven organizations and a youth organization. SAFE-WA meets quarterly to bring a united voice to the Mental Health Division's management on prominent children's issues.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Pierce County RSN** used MHBG funds to support family and youth empowerment through a program called A Common Voice.

Goal 4: Improve Client Perception of Care – Children/Youth

Individual choice, satisfaction, safety, and positive outcomes are the focus of services.

Objective 1: Promote consumer voice in service delivery

Performance Indicator: More than 50% of youth and parent/caregivers surveyed agree with the items on the MHSIP survey pertaining to timely and convenient access to mental health services. *This survey has been conducted every other year.*

2002: Not available
2003: 70.3% (Achieved) 922/ 1,311 = 70.3%
2004: Not available
2005: 70.6%
2006: Not available

Narrative: As indicated above the MHSIP surveys for Adults and Youths are conducted every other year. This is changing in 2007, however, in compliance with SAMSHAs requirement that NOMs be measured every year.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: More than 50% of youth and parent/caregivers surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year.*

2002: Not available
2003: 86.3% (Achieved) 922/1,311
2004: Not available
2005: 70.6% (Achieved) 762/1080
2006: Not available

Narrative: As indicated above the MHSIP surveys for Adults and Youths are conducted every other year. This is changing in 2007, however, in compliance with SAMSHAs requirement that NOMs be measured every year.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Improve the delivery of services to American Indian children

Performance Indicator: More than 50% of American Indian youth and parent/caregivers surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year.*

2002: Not available
2003: 84.3% (Achieved)
2004: Not available
2005: 86.7% (Achieved)
2006: Not available

Narrative: As indicated above the MHSIP surveys for Adults and Youths are conducted every other year. This is changing in 2007, however, in compliance with SAMSHAs requirement that NOMs be measured every year.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Pierce County RSN** used MHBG funds to support outreach and services specific to Native American youth in its catchment area.

Objective 3: Improve the delivery of services to ethnic minority children

Performance Indicator: More than 50% of ethnic minority youth and parent/caregivers surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year.*

2002: Not available
2003: 87.4% (Achieved)
2004: Not available
2005: 86.0%
2006: Not available

Narrative: As indicated above the MHSIP surveys for Adults and Youths are conducted every other year. This is changing in 2007, however, in compliance with SAMSHAs requirement that NOMs be measured every year.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Goal 5: Increase Employment or Return to School – Children/Youth

Increase cross-system collaboration to help children and youth to achieve in school and employment.

Objective 1: Increase school attendance

***Performance Indicator*:** Percentage of children/youth enrolled in mental health services who are currently attending school. (Developmental Table 19C)

2006: 90% (Planned)

Narrative: This measure is expected to come from survey for 2006 services not yet completed.

RSN Services: No RSN services were directly supported with MHBG funds

related to this Criterion, Goal, Objective.

Performance Indicator: Percentage of children enrolled in mental health services with satisfactory progress in school as evidenced by having the equivalent of a "C" or "Satisfactory" rating average.

2006: 75% (Planned) Not available at this time

Narrative: This measure is expected to come from survey for 2006 services not yet completed.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Support training on educational services for children

Performance Indicator: The MHD will support an annual early childhood conference to provide training on effective early intervention strategies, including services provided under the Individuals with Disabilities Education Act.

2005: Achieved
2006: Achieved

Narrative: The Boyer Clinic is the official sponsor of this highly valued and well-attended conference with MHD contributing MHBG funds to support it.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 3: Provide supported employment for youth

Performance Indicator: Over 25 youth with serious emotional disturbance will obtain supported employment positions.

2002: 73 (Achieved)
2003: 44 (Achieved)
2004: 36 (Achieved)
2005: 25 (Achieved)
2006: 45 (not Achieved) reported count is 26

Narrative: There has been a continued drop in supported employment for youth over the last several years. This is speculated to be related to financial losses sustained with CMS's change in interpretation regarding the use of Medicaid savings for non-Medicaid services. Advocates of youths with SED continue to keep this service available despite this downward trend.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 6: Decrease Criminal Justice Involvement – Children/Youth

Expand cross-system care coordination efforts within DSHS.

Objective 1: Provide support to children in juvenile detention facilities

Performance Indicator: Regional Support Networks will provide services to children served by the mental health system who also have contact with the criminal justice system. **(Developmental Table 19B)**

2003: 19.9% 8,370/ 42,075 = 19.9%
2004: Not available at this time
2005: Not available at this time
2006: Not available at this time

Narrative: Data collection for this Performance Indicator is quite complicated and requires information from other sources with significant delay. For example FY 05 data won't be available to MHD until 2007. Last year MHD reported FY 03 data for our DIG tables. We expect to have FY 04 by mid-December.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Provide services to youth released from juvenile justice facilities

Performance Indicator: Community mental health agencies will provide services to youth released from juvenile justice facilities.

2005: Achieved
2006: Achieved

Narrative: Although no formal count is offered for prevalence, this activity has occurred through RSN contracts utilizing MHBG funds.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Pierce County RSN** provided support to children and youth in the Remann Hall Juvenile Detention Facility, ensuring smooth transition and continued engagement in MH services.

Goal 7: Increase Social Services and Supports– Children and Youth

Implement peer support, after-school social services and advocacy activities for children and youth.

Objective 1: Support youth advocacy and social services

Performance Indicator: The MHD will support youth advocacy, social services, pre-vocational skill building, self-help and stigma reduction activities, which may also include funding to attend conferences, training and other mental health resource activities.

2005: Achieved
2006: Achieved

Narrative: MHD has sponsored and coordinated several youth focused activities. Youth attended the Federation of Families conference, were nominated by the MHD to have a seat at the mental health transformation workgroup table. Youth have also been involved in the Children's subcommittee of the Mental Health Planning and Advisory Committee. Through the contract with SAFE-WA a youth coordinator has been hired and he has met with a variety of different youth groups across the state to increase membership in Youth 'N Action, the youth group of SAFE-WA. Also, through the Transformation grant, a youth voice group has begun.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Increase the number of youth peer support counselors

Performance Indicator: The MHD will provide specialized training to youth so that they can become certified as peer support counselors.

2006: not Achieved

Narrative: Beginning coordination is occurring for youth peer counselors, however, as their were so many adult peer counselor applicants on the waiting list, the decision was made to postpone this activity to the second year of the grant cycle.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 8: Increase Family Stabilization and Living Conditions

Services promote natural and community supports including family, friends, and other citizens.

Objective 1: Provide out of facility services for children and their families

Performance Indicator: Maintain a statewide percentage of at least 15% of children/youth under the age of 18 who received outpatient mental health services in the home, at school, or outside the mental health provider agency at any time during the fiscal year.

2002: 55.4% (Achieved)
2003: 47.2% (Achieved)
2004: 50.0% (Achieved)
2005: 31.0% (Achieved)
2006: 50.10% (Planned) not available at this time

Narrative: Services being provided out of facility is encouraged whenever possible in an effort to decrease stigmatization and increase use of natural supports and resources.

RSN Services: No RSN services were directly supported with MHBG funds

related to this Criterion, Goal, Objective.

Objective 2: Include family participation in discharge planning

Performance Indicator: Maintain a percentage of at least 60% of youth and caregivers served agreeing or strongly agreeing with the items on the MHSIP Youth/Family Survey – Participation in Treatment Scale. *This survey is conducted every other year.*

2002: Not available
2003: 68.1% (Achieved) 894/ 1,313 = 68.1%
2004: Not available
2005: 69.5% 753/1,083 = 69.5%
2006: Not available

Narrative: As indicated above the MHSIP surveys for Adults and Youths are conducted every other year. This is changing in 2007, however, in compliance with SAMSHAs requirement that NOMs be measured every year.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 3: Promote inter-system collaboration

Performance Indicator: A minimum of 200 children with serious emotional disturbance will be served by at least one other agency in addition to mental health.

Program areas	2002	2003	2004	2005	2006
MHD / Juvenile Rehabilitation	887	896	923	710	unavailable
MHD / Developmental Disabilities	1,517	1,331	1,313	1,208	unavailable
MHD / Substance Abuse	2,351	2,463	2,573	2,282	unavailable
MHD / Children's Services	13,787	13,811	14,566	14,322	unavailable

Narrative: Through the collaboration of the Children's Mental Health Initiative, continued progress is expected in this area. The goal for this objective is consistently exceeded.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 4: Support parent advocacy activities

Performance Indicator: The MHD will support parent advocacy, self-help, and stigma reduction activities, which may also include funding to attend conferences, training and other mental health resource activities.

2005: Achieved
2006: Achieved

Narrative: In addition to the above activities, the youth have been working on a *Youth Guide to the Public Mental Health System.* This guide is designed to emulate the *Parents guide to the Public Mental Health System.* The youth guide

is being tested across the state to be youth friendly and helpful to youth. In its final state, it will describe the feeling a youth might be experiencing, the services they can expect to receive, and also many other resources available to them. The parent guide has been updated to include changes that have occurred over this past year in the public mental health system.

A parent training was held in September for parents that are accessing the system for the first time. We had 95 registrations however sue to limited space were only able to accept 64. For the Mental Health Division staff that have participated in this training since 1993, the most exciting outcome was that each workshop was conducted by a parent that at one time was "the new parent accessing the system". The parent presenters had all come to be part of the parent advocacy movement through this training process earlier on in their lives. They felt it to be a great way to give back to the system. The new parents felt both relieved to learn they were not alone, and empowered to move forward.

As an interesting side note, staff was impressed to see the number of parents at this training that identified themselves first as parents and second as a professional in the field. As a stigma reduction outcome, this was the first time in over 13 years of this type training this had occurred.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Peninsula RSN** used MHBG funds to support Bridges to Parent Voice program to provide education to parents about available community services and how to access those services for their child. Support also allowed for participation in at least 60 outreach activities designed to empower families to utilize community resources.

Goal 9: Children/Youth with Co-Occurring Substance Use Disorders

Improve the delivery of services through an integrated approach to effectively respond to the special needs of children and youth with co-occurring disorders.

Objective 1: Increase services for children/youth with co-occurring disorders

Performance Indicator: Number of children with a co-occurring disorder who were served by the Mental Health Division and the Division of Alcohol and Substance Abuse.

2002: (Achieved) 6.5 %
2003: (Achieved) 6.6 %
2004: (Achieved) 6.6% 2,575/38,835 = 6.6%
2005: (Achieved) 6.1% 2,282/ 37,306
2006: (Planned) not available at this time

Narrative: Co-occurring services for youth continue to be a priority for both MHD and DASA, though much more needs to be done in terms of resource development and access to services.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Provide integrated treatment for co-occurring disorders

Performance Indicator: Number of children and youth receiving dual diagnosis treatment for mental health and substance abuse interventions at the level of the clinical encounter. **(Developmental Table 17)**

2005: 2,880
2006: Planned

Narrative: Please see narrative above.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Performance Indicator: The MHD will provide annual statewide training on integrated mental health and chemical dependency treatment for children and youth.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Goal 1: Improve Family Stabilization and Living Conditions

Increase the availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, including a full range of residential services and residential supports prescribed in the consumer's treatment plan.

Objective 1: Continue to support PATH programs

Performance Indicator: The MHD will apply for annual renewal of the Programs to Aid in the Transition from Homelessness (PATH) grant.

2005: Achieved
2006: Achieved

Narrative: For the past three (3) years, MHBG funds have been used to support several facilitated planning sessions in various parts of the state. Common Ground, a well established private, non-profit housing specialty agency, has conducted the planning sessions in RSNs designated by the state PATH contract. The planning sessions have occurred primarily in locations where there was no current PATH project.

Planning sessions have been provided in six locations around the state in the last three years. Two new PATH projects have been established among the six planning recipients. One location applied for and received federal housing funding to establish a twelve unit facility to serve mentally ill people.

MHBG funds were used to support the annual Washington State Coalition for the Homeless state conference in May 2005. PATH recipients and others who serve

homeless, mentally ill people received financial assistance to support their attendance at the conference.

This year, in addition to support for people to attend the annual conference on homelessness, board members of the Coalition were sponsored to attend the annual behavioral health conference coordinated by Washington Community Mental Health Council under contract with MHD. These two efforts are intended to promote greater interaction and coordination of efforts among providers of mental health and housing services locally and statewide.

As a recipient of PATH grant funds and with additional SAMHSA technical assistance, Washington has also been involved in promoting SSI/SSDI Outreach Access and Recovery (SOAR) for the last year and a half. A joint training project with PATH in Oregon was staged in March 2005. Subsequently, in the fall of 2005, MHD sponsored PATH training conducted through the SOAR project. MHD also has assisted staff from Washington, who attended SOAR train the trainers training in Washington, D.C. in December 2005, to arrange training for PATH and other providers of services to homeless people.

The RSNs with the highest estimated numbers and percentages of homeless mentally ill are listed in the table below. There are PATH projects in seven of the eight RSNs with highest percentages and numbers of projected homeless mentally ill people. Previously there was a PATH project in Clark RSN, but a decision was made locally not to continue the project.

STATE OF WASHINGTON 2003 Final Homelessness Mental Illness Estimates by RSN					
RSN	Estimated Number of Homeless Persons	# Homeless SMI Using 35% Estimate	Total Pop (2000 Census)	% Homeless SMI to Population	PATH Funding
Spokane	3,699	1,295	417,939	0.310	Yes
King	7,980	2,793	1,737,034	0.161	Yes
Pierce	2,698	944	700,820	0.135	Yes
Clark	1,071	375	345,238	0.109	Declined
Peninsula	1,001	350	322,447	0.109	Yes
Greater Columbia	1,711	599	599,730	0.100	Yes
North Sound	2,711	949	961,452	0.099	Yes
Thurston-Mason	724	253	256,760	0.099	Yes
North Central	369	129	130,690	0.099	DNA
Chelan-Douglas	280	98	99,219	0.099	DNA
Timberlands	263	92	93,408	0.099	Withdrew
Southwest	262	92	92,948	0.099	Yes
Northeast	195	68	69,242	0.099	DNA
Grays Harbor	189	66	67,194	0.099	DNA
State Totals	23,154	8,104	5,894,121	0.137	

DNA--Did not apply

Although PATH funding is targeted to outreach and engagement of seriously mentally ill, homeless adults, the broader range of services listed below are integrated and augmented with additional local funds:

- Outreach and Engagement
- Screening and Diagnostic Treatment
- Habilitation and Rehabilitation
- Community Mental Health Services
- Alcohol or Other Drug Treatment
- Staff Training
- Case Management Services
- Referrals for Primary Health Services, Education Services, Job Training, and Housing Services
- Technical assistance in applying for housing

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 2: Develop residential and housing capacity

Performance Indicator: The MHD will assess needs, set priorities, develop residential and housing capacity and increase cross-system collaboration.

2005: Achieved
2006: Achieved

Narrative: MHD is beginning to move beyond the needs assessment this year and is focusing considerable resources on plan development and cross-system collaboration with regards to housing. MHD Director has made this a top priority for this next year; further generating momentum through the STI related to a Housing Plan. On the community level, each RSN is also being expected to participate in garnering local resources or county funding where available.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **North Central RSN** used MHBG funds to Maintain rental duplex for the homeless individuals suffering from mental illness. The duplex would be kept available to place these individuals until such time as other more permanent housing is arranged and adequate housing supports are in place

Objective 3: Provide ongoing support services to homeless persons

Performance Indicator: Regional Support Networks will maintain the statewide percentage of adult outpatient service recipients age 18 years and older who had an independent living situation as their primary residence at any time during the fiscal year at a rate greater than 60%.

2002: 56.3% (Achieved)
2003: 64.5% (Achieved)
2004: 63.8% (Achieved) 58,706/92,214
2005: 64.4% (Achieved) 56,817/ 88,291
2006: 66.0% (not Achieved) 63.7% 53,846/ 84,470

Narrative: The overall Performance Indicator of maintaining at least 60% of adult outpatient service recipients who had an independent living situation as their primary residence at any time during the fiscal year has been consistently met; however the individual target for this year of 66.0% was a little robust.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Spokane County RSN** used MHBG funds to support the Homeless Outreach Team which provided ongoing supportive services, including medication monitoring, case management, drug and alcohol treatments to homeless, non-Medicaid consumers.

Performance Indicator: Regional Support Networks will maintain the statewide percentage of children/youth outpatient service recipients age 18 years and under whose primary residence was listed at any time as their own home, foster care, or "other" at any time during the fiscal year at a rate greater than 75%.

2002: 82.8% (Achieved)
2003: 85.8% (Achieved)
2004: 82.2% (Achieved)
2005: 83.6% (Achieved)
2006: 84.2% (not Achieved) 82.1%

Narrative: The overall Performance Indicator of maintaining the statewide percentage at 75% of children/youth outpatient service recipients age 18 years and under whose primary residence was listed at any time as their own home, foster care, or "other" at any time during the fiscal year at a rate greater than 75% was exceeded; however the 2006 target of 84.2% was not.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **King County RSN** used MHBG funds to support Homeless Outreach, Stabilization and Transition (HOST) providing outreach, engagement, and intensive stabilization services to homeless people who also have a mental illness.

Performance Indicator: Regional Support Networks will maintain the proportion of adult outpatient service recipients who were homeless at some point in time during the fiscal year at less than 15%.

2002: 6.0% (Achieved)
2003: 7.4% (Achieved)
2004: 7.1 % (Achieved) 6,574/92,250 = 7.1 %
2005: 7.7% (Achieved) 6,765/ 88,348 = 7.7 %
2006: 8.0% (Achieved) 6,737/ 84,471 = 8.0 %

Narrative: As noted above, homelessness is a serious and important issue to MHD as evidenced by efforts to create a statewide Housing Plan.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 4: Provide outreach services to homeless and at-risk youth

Performance Indicator: Regional Support Networks will serve more than 50 rural and homeless youth.

2002: 104 youths served (Achieved)
2003: 121 youths served (Achieved)
2004: 106 youths served (Achieved)
2005: 111 youths served (Achieved)
2006: 113 (not Achieved) 98 youths served

Narrative: The Performance Indicator for this Objective has been consistently exceeded by double. However, the target for 2006 was higher than obtained.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 5: Provide support services for homeless children and their families

Performance Indicator: Regional Support Networks will maintain a statewide percentage of under 5% of children/youth outpatient service recipients whose primary residence was listed as homeless in the fiscal year and number of hours of service.

2002: 5.3% (Achieved)
2003: 1.6 % (Achieved)
2004: 1.6 % (Achieved) 618/ 39,091
2005: 1.6% (Achieved) 609/ 37,661
2006: 2.0% (Achieved) 1.4% 517/ 36,219

Narrative: The Performance Indicator for this Objective has been consistently met. The targeted goal for 2006 was exceeded.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 2: Improve services to consumers in rural areas

Objective 1: Provide community-based services to consumers in rural areas

Performance Indicator: Regional Support Networks will provide services to a minimum of 25,000 persons in rural areas.

2002: 40,138 persons served; 774,952 service hours (Achieved)
2003: 55,577 persons, or 1,093,138 hours
2004: 57,024 persons, or 1,001,423 hours
2005: 59,267 persons or 905,380 hours
2006: 46,000 (Achieved) 55,042 persons or 810,511 hours

Narrative: The Performance Indicator for this Objective has been consistently met. The targeted goal for 2006 was exceeded.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Spokane County RSN** used MHBG funds to support Spokane Neighborhood Action Plan (SNAP) which provides community-based services to consumers in rural area. SNAP provides various housing assistance, such as: emergency shelter, transitional housing, Rural Rental Assistance, and more. SNAP also provides family development coaching, case management, and support services (including Outreach services) to

homeless families and individuals residing in Spokane County. Life skills training, education, and employment classes are also provided. Total service hours equaled 580.

Objective 2: Provide training on services to consumers in rural areas

Performance Indicator: The MHD will support training activities on the specialized needs of consumers in rural areas.

2005: Achieved
2006: Achieved

Narrative: This was accomplished through training events with the State Behavioral Health Care Conference as well as through Olmstead Grant funding which supported a series of 6 state-wide trainings geared toward providers addressing ways in which to better support persons with challenging issues within their own communities. 3 of these trainings were conducted in largely rural areas of the state and involved education providers on their community resources and focused on improving access to the specialized needs of this population.

RSN Services: The following RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

- **Spokane County RSN** used MHBG funds to support the rural homeless outreach program of Spokane Neighborhood Action Plan (SNAP) through a family Development Specialist who provided 16 life skill classes in goal-setting, conflict resolution, money management, tenant/ landlord law, renters responsibility, relationship building, how to find a job, healthy choices and credit enhancement. Over 400 training hours were provided.

CRITERION 5: Management Systems

Goal 1: Support research and quality improvement activities

Objective 1: Convene statewide Quality Improvement Groups

Performance Indicator: The MHD will convene workgroups for the development of system change through statewide Quality Improvement Group activities.

2005: Achieved
2006: Achieved

Narrative: Several Quality Improvement Groups have convened around issues of Performance Indicators and data integrity as well as Utilization Management related to RSN usage of Inpatient Services.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Support the Consumer Roundtable Committee

Performance Indicator: The MHD will provide support to the Consumer Roundtable as a forum to gather consumer voice from around the state and provide input for the development of system improvement.

2005: Achieved
2006: Achieved

Narrative: Consumer Roundtable was conducted only once in this FFY due to change in staffing of Office of Consumer Affairs, under which this activity operates. MHPAC has assisted MHD in re-writing the job description for this position and MHD will begin active recruitment in the coming months.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 3: Conduct consumer/family satisfaction surveys

Performance Indicator: The MHD will contract with the Washington Institute for Mental Illness Research and Training to conduct a satisfaction survey of consumers and their families using the Mental Health Statistical Improvement Project (MHSIP). *Children/youth and adults will each be surveyed on alternate years.*

2005: Children -Achieved
2006: Adults – Achieved

Narrative: Efforts have been made to begin conducting these surveys each year for both children and adults in compliance with SAMHSA requirements related to National Outcome Measures reporting.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 4: Support the Quality Review Team function

Performance Indicator: The MHD will provide training and support to RSN Quality Review Team members.

2005: Achieved
2006: Achieved

Narrative: This is ongoing with scheduled trainings conducted several times per year supported by MHD's portion of the MHBG through contract with WIMIRT.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Goal 2: Promote a highly skilled workforce

Objective 1: Provide training for providers of emergency health services

Performance Indicator: The MHD will provide community education on mental health and mental illness to providers of emergency health services, law enforcement and other

first responders as evidenced by supporting Washington Association of County Designed Mental Health Professional (WACDMHP) conferences.

2005: Achieved
2006: Achieved

Narrative: While MHD is currently supporting four (4) CIT trainings across the state, many RSNs have partnered with their local NAMI and law enforcement officials to provide this valuable training. For example, Clark County RSN alone reports having trained over 400 officers to date. MHD also used MHBG funds to support 4 Safety Summits addressing the safety of crisis workers, consumers, law enforcement workers and Designated Mental Health Professionals in the process of evaluation persons in crisis and assessing for involuntary commitment. Another collaborative effort of MHD with the Division of Developmental Disabilities (DDD) yet another example of training provided to emergency and health providers is the Community Hospital MI/DD Training. Together, the Divisions are creating a training targeted to the community hospitals that serve persons with a dual diagnosis of mental illness and develop mental disability on how to better understand, evaluate, triage, and treat this special population. Training is being provided to both Emergency Room staff as well as employees who would be providing inpatient treatment.

MHD is committed to providing training to the State's emergency and health providers. As the first responders, emergency and health providers being well trained and educated about persons with mental illness and available services will only help move our state toward ***Transformation***.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective.

Objective 2: Provide training on disaster mental health services

Performance Indicator: The MHD will provide training specific to emergency/disaster outreach services and the Crisis Counseling Program to assure improved coordination amongst disaster outreach workers so that those who individuals who are in need of additional mental health assessment and services are referred to appropriate resources.

2005: Achieved
2006: Achieved

Narrative: Again, MHD used the State Behavioral Health Care Conference to conduct pre-conference sessions on Disaster Mental Health. In addition to this, however, was the training and coordination of the KATRINA efforts, Operation Evergreen.

As the state's Disaster Mental Health Coordinator, MHD took the lead in orchestrating the necessary services to be provided to evacuees of Hurricane Katrina who came to Washington. Under the direction of Governor Christine Gregoire, Emergency Operations were activated during Labor Day Weekend, 2005. Emergency management staff planned for the arrival of up to 2000 Gulf Coast evacuees by adapting the Washington Repatriation Plan to meet the circumstances of the disaster. The revised plan, known as

Operation Evergreen, was based upon the assumption that as many as 2000 evacuees would arrive in Washington with little or no warning.

Throughout Operation Evergreen, the daily counts reported by the American Red Cross continued to rise. Individuals and families were unexpectedly arriving on their own around the state. Evacuees hitchhiked, rode buses and airplanes or used some combination of transportation to get to Washington. One New Orleans cab even made the trip. Some relied on hurricane relief funds while others had transportation purchased by friends or loved ones already in Washington.

As of September 30th, 2005, estimates for evacuees ranged as high as 4,599. The table below outlines the avenues of initial contact:

Date	Source	Indicator
10/10/05	FEMA Registrations	1,717 registrations
10/05/05	FEMA Registrations	1,651 registrations
09/25/05	FEMA Registrations	1,498 registrations
09/25/05	FEMA Registrations	1,435 registrations
09/28/05	American Red Cross	582 mental health contacts
09/26/05	American Red Cross	957 cases opened
09/26/06	Office of Superintendent of Public Instruction (note: data submission by the 296 school districts was voluntary, so estimated numbers are higher than reported)	232 enrollments
10/07/05	DSHS – Community Service Office	564 family units/ 1,042 guests applied for benefits
09/26/05	DSHS – Community Service Office	431 family units/ 834 guests applied for benefits
10/10/05	Disaster Assistance Hotline	>700 calls received
09/27/05	Homeless Shelters	Two shelters reported serving evacuees

To aid in coordinating the delivery of comprehensive support to the "guests" in our state, a "one-stop" ***Welcome Center (WC)*** was equipped and opened Memorial Day weekend in Tumwater (just south of Olympia). The WC offered driver's license replacement, issuance of identification, determination of eligibility for public assistance and disaster related entitlements, free pet care services and vaccinations, pediatric health screens, American Red Cross services, disaster counseling, employment resources, housing assistance and access to communication through the internet and use of cell phones, assistance with FEMA registration, coordination and scheduling of transportation, and breakfast/lunch, snacks and childcare. More than 90 families/individuals utilized the WC during its seven days of operation. The operation was closed when it appeared that the

evacuees were well-connected with area services which were able to assist in meeting individuals' basic needs and help them move forward in their personal journeys through this life-changing natural disaster.

In addition to the Welcome Center, the mental health system was mobilized to meet the mental health needs of evacuees, many of whom were in need of continuing mental health treatment. Through the creation of the ***Crisis Counseling Program***, Five (5) regions were identified to be partners in the provision of emergency counseling services by virtue of their locations and number of evacuees: King, Pierce, Clark, Snohomish and Spokane. Each region then contracted with a local Community Mental Health Center for the delivery of direct care services.

Every outreach crisis counselor and key personnel from each region received two (2) days of training provided through a consultant coordinated by the Disaster Technical Assistance Center. An additional day of training was provided by FEMA Region X to share information about the FEMA benefits and programs that were available to evacuees.

Overall, types of services provided to evacuees included:

- Individual Crisis Counseling
- Group Counseling
- Education (including direct mailing of informational packets sent to all of the FEMA registrants, flyers posted in public areas, and a media campaign of public service announcements and press releases)
- Referrals (e.g. area volunteer services, churches, Community Mental Health Agencies for longer team mental health treatment Services).
- Toll Free Hotline

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

Objective 3: Provide training on vocational services

Performance Indicator: The MHD will support a vocational track at the Washington State Behavioral Health Conference providing training on best practices related to club houses, supported employment, and other related issues.

2006: Achieved

Narrative: This year's BHC Conference was noted to be one of the best ever. This was due in large part to the number of consumer scholarships provided by MHD with MHBG funding. In addition to the workshops at the conference, MHD also used MHBG funds to support a separate training for RSN Administrators on how to go about setting up an ICCD Club House. For this training MHBG funds also supported members of Fountain House being flown to Washington. The result was nearly 40 people being trained on the "how to" of ICCD Club House organization and implementation.

RSN Services: No RSN services were directly supported with MHBG funds related to this Criterion, Goal, Objective:

DRAFT

EVIDENCE-BASED PRACTICES USED BY MENTAL HEALTH PROVIDERS IN WASHINGTON STATE

October 2006

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Page

TABLES

FIGURES

EVIDENCE-BASED PRACTICES USED BY MENTAL HEALTH PROVIDERS IN WASHINGTON STATE

EXECUTIVE SUMMARY

In 2006, the Mental Health Division (MHD) contracted with the Washington Institute for Mental Illness Research and Training (WIMIRT) to conduct a statewide survey of mental health providers. The goal of the survey was to collect information about the utilization of Evidence-Based Practices (EBPs) in Washington State. Of 150 eligible mental health facilities, 67 completed the survey, yielding a 45% response rate. Selected findings include:

- Approximately three-fourths (78%) of the responding facilities were implementing at least one EBP and more than half (61%) were implementing more than one.
- Facilities are implementing fewer EBPs for children (35% offer at least one EBP for children) than for adults (67% offer at least one EBP for adults).
- The most frequently implemented EBPs for Adults were Family Psychoeducation (37%) and Integrated Treatment for Co-occurring Mental and Substance Abuse Disorders (36%).
- The most frequently implemented EBP for Children was Multisystemic Therapy (19%).
- Among those responding to the survey, Illness Management and Recovery services were provided to the greatest number of people (n=14,412), followed by Medication Management (n=13,744).

- With the exception of facilities implementing Supported Employment or Functional Family Therapy, less than half monitor program fidelity for the EBPs they currently provide.
- The most frequent barrier to EBP implementation, regardless of which specific EBP was examined, was “Financial”.

Implications of the current study include: 1) educating policy makers and clinicians about the importance of monitoring EBP fidelity and the potential cost-effectiveness of using EBPs; 2) investigating the factors responsible for successful EBP dissemination and implementation; and 3) exploring creative ways to combine resources from mental health, Medicaid, criminal justice, vocational rehabilitation, and other funding sources to support evidence-based services.

I. INTRODUCTION

Evidence-based practices, or EBPs, refer to practices and procedures for which there is consistent scientific evidence showing that they improve consumer outcomes (Drake, Goldman, Leff, et al., 2001). Although a variety of pharmacological and psychosocial interventions are available to treat most mental disorders, the extent to which EBPs are utilized in real world settings is limited (Gold, Glynn, and Mueser, 2006; Wang, Berglund, and Kessler, 2000).

Despite the gap between research and practice, the public mental health system is moving forward with EBP implementation. Both national and state mental health leaders are emphasizing the importance of providing services with demonstrated clinical effectiveness (Esenwein, Bornemann, Ellingson, Palpant, Randolph, & Druss, 2005) and states are now required to report the number of children and adults who receive EBPs to the Center for Mental Health Services (CMHS). According to information collected from 48 State Mental Health Agencies (SMHA), every state, including Washington, was offering at least one EBP in Fiscal Year 2004, and most were offering more than one (National Association of State Mental Health Program Directors Research Institute, Inc., 2004).

In order to gain a better understanding of EBP implementation in Washington State and to meet the Substance Abuse and Mental Health Services Administration (SAMSHA) reporting requirements, DSHS Mental Health Division (MHD) contracted with the Washington Institute for Mental Illness Research and Training (WIMIRT) to conduct an online survey that would collect the following information: 1) the number of facilities that currently implement or plan to implement EBPs for children and adults; 2) the number of individuals that receive EBPs; 3) the number of facilities that are measuring EBP fidelity; and 4) barriers to EBP implementation. Ten SAMHSA supported EBPs were the major focus of this report. They are:

- Assertive Community Treatment (ACT)

- Supported Employment
- Supported Housing
- Family Psycho-education
- Integrated Treatment for Co-occurring Disorders
- Illness Management/Recovery
- Medication Management
- Multisystemic Therapy (MST)
- Therapeutic Foster Care
- Functional Family Therapy (FFT)

II. METHOD

Survey Design

The survey consisted of 57 questions (see Appendix B), 14 of which were adapted from the State Mental Health Agency Profiles System developed by the NASMHPD Research Institute (NRI). The purpose of the survey was to gather the following pieces of information:

A) The Number of EBP Programs. Respondents were asked to indicate whether their facility currently implements or is planning to implement each of the 10 EBPs listed above. They were also asked about other innovative or promising practices they are currently implementing.

B) The number of children and adults receiving EBPs. As part of SAMHSA's Uniform Reporting System (URS), MHD is required to provide information on the number of children and adults who receive EBPs. To satisfy this requirement, each respondent was asked to report the number of children and adults who received each EBP in Fiscal Year 2005.

C) EBP Fidelity. A number of studies have shown that fidelity, or the degree to which an

intervention is provided as intended, is associated with better client outcomes (McHugo, G.J., Drake, R.E., Teague, G.B., & Xie, H., 1999). Therefore, respondents were asked whether their facility measures program fidelity for the EBPs they currently provide. In addition, in order to fulfill federal block grant reporting requirements, a set of pilot questions was developed to assess whether facilities are satisfying EBP fidelity requirements as outlined by the Data Infrastructure Grant (DIG) Coordinating Center.

D) Barriers to EBP Implementation. Respondents were asked to identify any barriers to implementing each EBP.

Data Collection Procedures

The field period for this survey ran from March, 2006 to June, 2006. Prior to conducting the survey, MHD gave WIMIRT a list of 200 community inpatient and outpatient mental health facilities in Washington State. The list included the name and address of each facility as well as the name and phone number of the facility administrator. In late February 2006, the facility administrator at each agency was sent a letter alerting them to expect two surveys: one examining the utilization of EBPs and the other examining the treatment of co-occurring disorders (Appendix A). The letter included a request to e-mail, fax, or phone WIMIRT with the name and phone number of a contact person who would be most appropriate to complete the survey.

If the facility administrator did not respond to this request, they were telephoned and asked to provide contact information. Once contact information was obtained, the following steps were taken to collect survey data:

1) First, the contact person was e-mailed a letter informing them that they would be receiving the survey (see Appendix A).

2) One to two weeks after the initial email, the contact person was sent a cover letter with instructions on how to complete the survey (see Appendix A). A Microsoft Word copy of the survey was attached to each email. The contact person was informed that he

or she could respond to the survey using one of three methods: by web-based data entry; by US mail; or by sending it to WIMIRT as an email attachment. To limit web-based data entry only to those in the sample, each facility was given a custom ID. The contact person was instructed to complete the survey within 2 weeks of receiving the cover letter.

3) If the contact person did not complete the survey, they were sent a reminder/thank you email 2 to 4 weeks after receiving the cover letter email.

4) If the contact person still did not complete the survey, they were telephoned and either asked to complete the survey or, if unavailable, they were left a voice mail message to complete the survey.

Respondents

Survey participation was voluntary. Of the 200 facilities that were in the survey universe, 10 facilities only provided crisis services and were excluded from the sample. Nineteen facilities were found to be ineligible to take the survey because they were either closed or were not providing direct mental health services. An additional 21 facilities were "rolled into" other facilities counts and therefore were not reported separately. These were facilities that managed satellite facilities and reported facility characteristics and client counts for their own facility and for other facilities. This left 150 facilities that were eligible to participate.

Of 150 eligible facilities, eight facilities had incorrect contact information (either phone numbers or addresses) and could not be located on the internet (see Table 1). Twenty-one facilities would not give WIMIRT contact information regarding who should fill out the survey and therefore were considered refusals. Despite email and telephone prompting, staff at 54 facilities did not complete the survey, and were given a "No Response" disposition. The survey was completed by staff at 67 facilities, yielding a response rate of 45%. Three facilities (4%) returned the survey via mail, 15 facilities (22%) returned the survey via e-mail, and the remaining 49 facilities (73%) completed the survey online. The majority of respondents identified themselves as

Program/Clinical Directors but the sample also included Chief Executive Officers (CEO), Vice Presidents, and Clinical Supervisors/Therapists.

Table 1: Dispositions of the Sample

	N	%
Incorrect number/address	8	5
Refusal	21	14
No Response	54	36
Complete	67	45
Total	150	100%

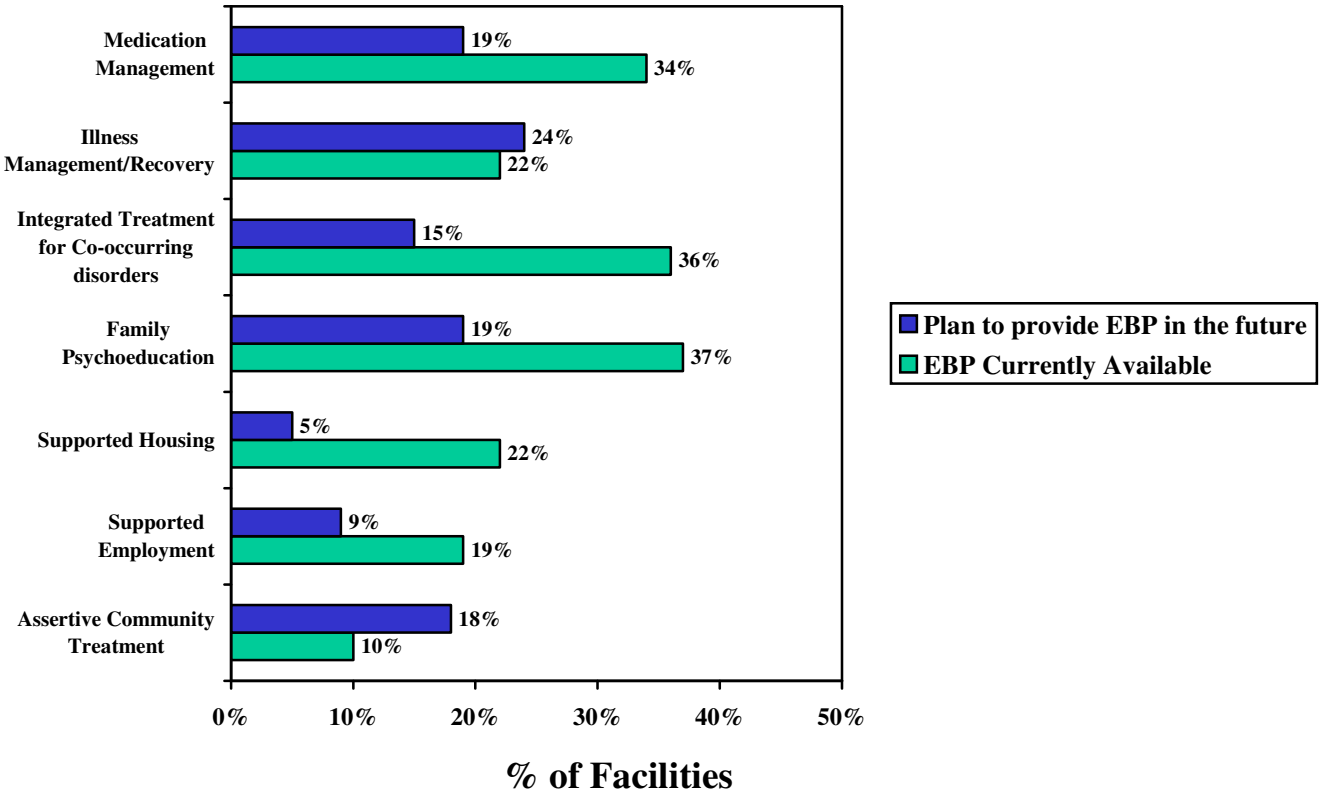
III. RESULTS

A. Number of EBP Programs

Overall, seventy-eight percent (n = 52) of the facilities reported providing at least one of the 10 EBPs listed above and 61% (n = 41) indicated that they are implementing two or more EBPs.

Adults. The percentage of reporting facilities that are implementing or planning to implement adult EBPs is presented in Figure 1. It should be noted that facilities planning to implement a particular EBP are different from facilities that are currently implementing that EBP. Information about whether a facility will continue to provide each EBP in the future was not collected.

Figure 1: Percent of Reporting Mental Health Facilities Implementing or Planning to implement Adult EBPs, N = 67



Taken as a whole, 64 percent (n=43) of the surveyed facilities indicated that they are currently implementing at least one adult EBP. The three most frequently implemented adult EBPs were Family Psychoeducation (37% of the sample; n=25), Integrated Treatment for Co-occurring Disorders (36%; n=24), and Medication Management (34%; n=23).

Approximately one-fifth of the facilities reported that they currently implement Supported Housing (22%; n=15), Illness Management and Recovery (n=15; 22%), and Supported Employment (19%; n=13). The least commonly implemented adult EBP was Assertive Community Treatment (10%; n=7).

The mental health facilities reported similar trends in relation to future plans for implementation. Approximately one-fourth to one-fifth of the facilities have plans to implement Illness Management and Recovery (24%; n=16), Family Psychoeducation (19%; n=13), Medication Management (19%; n=13), and ACT (18%; n=12) services in the future. Fifteen percent of the facilities have plans to implement Integrated Treatment for Co-occurring Disorders. Less than 10 percent of the reporting facilities have plans to implement Supported Housing (5%; n=3) or Supported Employment (9%; n=6) services.

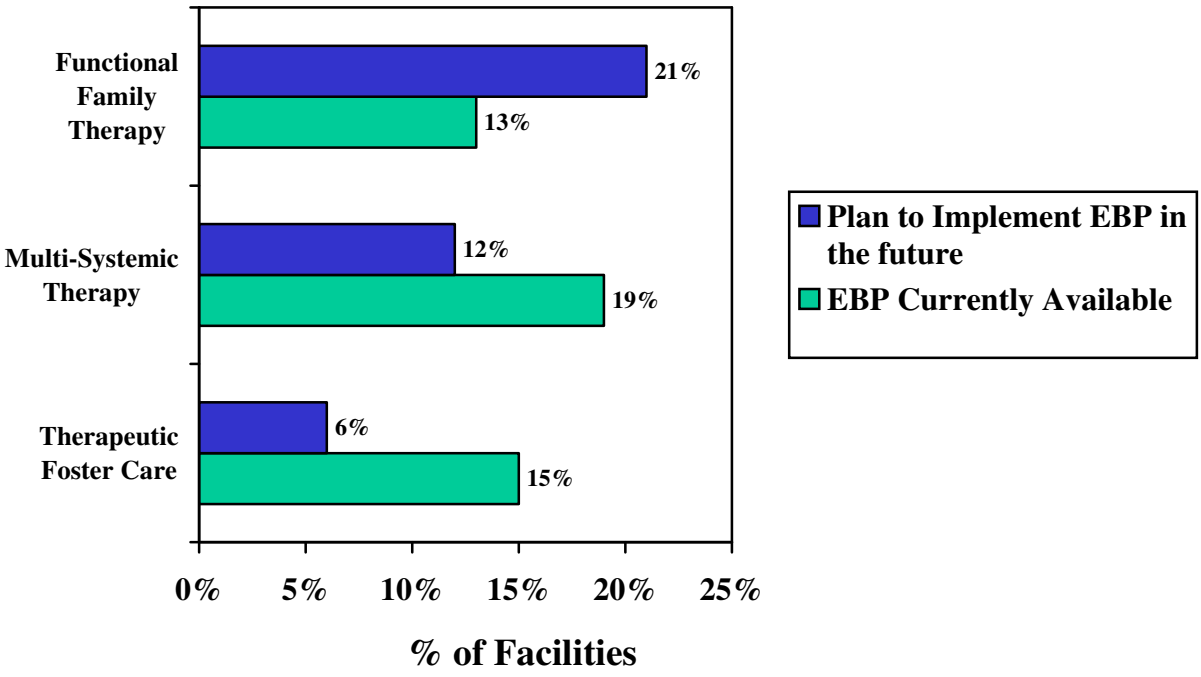
When asked about other EBPs or promising practices the facility was implementing or planned to implement in the future, the most common response was Dialectical Behavior Therapy or (12%; n=8), followed by Cognitive Behavior Therapy (8%; n = 5). Fewer than 5% of the respondents mentioned other EBPs or promising practices.

Children. The percent of reporting facilities implementing or planning to implement EBPs for children is presented in Figure 2. Overall, fewer facilities are offering EBPs for children than for adults. Thirty-five percent (n=25) of the 67 facilities indicated they are currently administering any of the EBPs for children. Nineteen percent of the facilities (n=13) are implementing Multisystemic Therapy, 15 percent (n=10) are implementing Therapeutic Foster Care, and 13 percent (n=9) are implementing Functional Family Therapy.

The highest percent of facilities (21%) have plans to implement Functional Family Therapy in the future, followed by Multisystemic Therapy and Therapeutic Foster Care.

When asked about other children's EBPs or promising practices the facility was implementing or planned to implement in the future, the most common response was Cognitive Behavior Therapy (15%; n= 10), followed by Dialectical Behavior Therapy (9%; n = 6) and Wraparound Services (4%;n=3).

Figure 2: Percent of Mental Health Facilities Implementing or Planning to Implement Children's EBPs, N=67

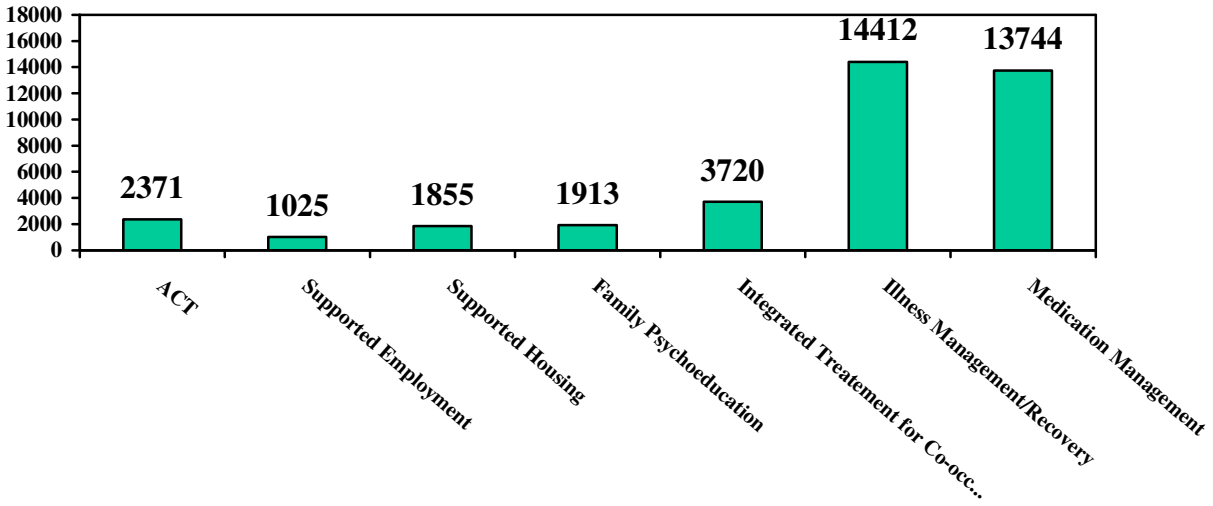

Functional Family Therapy
21%
13%
Multi-Systemic Therapy
12%
19%
Therapeutic Foster Care
6%
15%
0%
5%
10%
15%
20%
25%
% of Facilities
Plan to Implement EBP in the future
EBP Currently Available

B. Number of individuals who received EBPs in the Surveyed Facilities.

Adults.

The number of adults that received each EBP *in the surveyed facilities1* during FY2005 is presented in Figure 3. Illness Management and Recovery services were provided to the most number of people (n=14,412)2, followed by Medication Management (n=13,744), Integrated Treatment for Co-occurring Disorders (n=3,720), Assertive Community Treatment (n=2,371), Family Psychoeducation (n=1,913), and Supported Housing (n=1,855). Among the adult EBPs, the fewest number of consumers received Supported Employment services (n=1,025).

Figure 3: Number of Adults Receiving EBPs in the Surveyed Sites



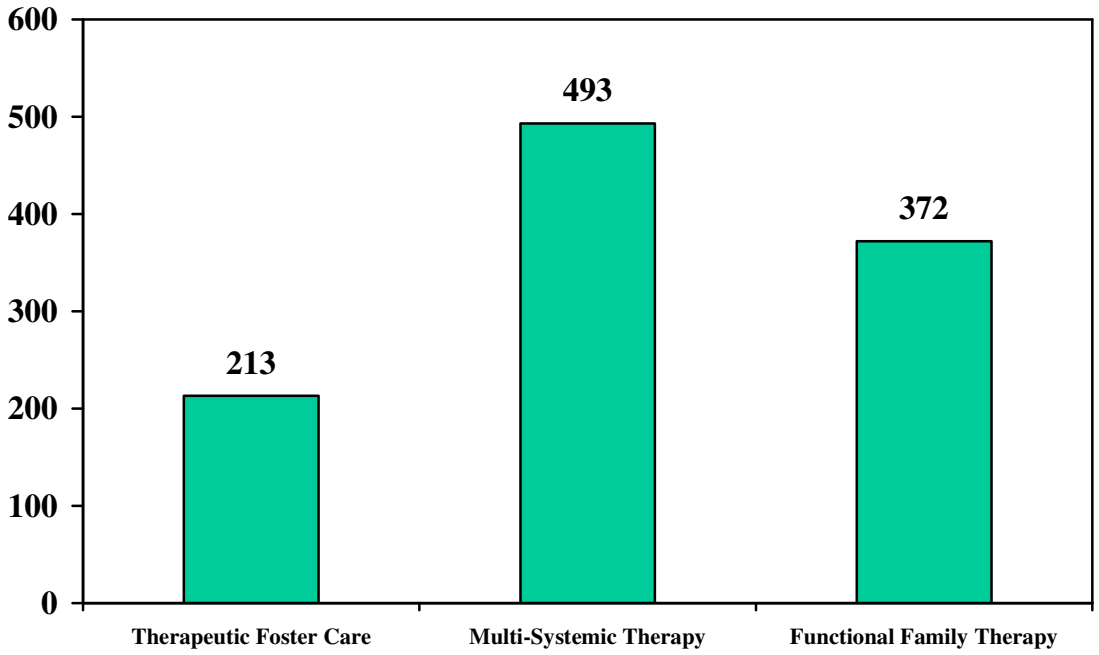
1 The numbers represent only those consumers receiving evidence-based practices within the 67 surveyed sites. It does not include all of those receiving services throughout the State of Washington. It should also be noted that these numbers are not restricted to only persons with serious mental illness.

2 One of the facilities (within King County) accounted for 76% of the consumers provided with this EBP (n=11,011).

Children

The number of children *in the surveyed facilities* that received Multisystemic Therapy, Therapeutic Foster Care, and Functional Family Therapy during FY2005 is presented in Figure 4. Similar to the difference in the number of facilities that are implementing adult compared with child EBPs, the number of children receiving EBPs is substantially less than the number of individuals receiving adult EBPs. Specifically, mental health facilities reported that 493 children received Multisystemic Therapy (n=493), followed by Functional Family Therapy (n=213), and Therapeutic Foster Care (n=213).

Figure 4: Number of Children Receiving EBPs in the Surveyed Sites, FY2005



C. EBP Fidelity

All facilities who responded to the survey were asked to indicate whether they measured program fidelity for the EBPs they currently provide (see Figure 5). In addition, to help assess whether minimum DIG reporting requirements are being met, a set of pilot questions were developed for nine of the 10 EBPs. Responses to individual questions for each EBP are presented in Appendix C. Because the Washington Institute was simultaneously administering another provider survey examining the integrated treatment of co-occurring disorders during the administration of the current survey, pilot questions were not developed to assess the fidelity of Integrated Treatment for Co-occurring Disorders (MH/SA).

Assertive Community Treatment (ACT). Of the seven facilities that said they were currently offering ACT services, two (29%) reported that they measure ACT program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting ACT were as follows:

- Small Caseload: The average provider to client ratio was 1:8, and ranged between 1:4 and 1:15. Four out of seven facilities (57%) reported a provider to client ratio of 1 to 10 or fewer.
- Multidisciplinary Team Approach. Six (86%) facilities indicated that they emphasized a team approach "All of the Time" or "Most of the Time" rather than an approach that emphasized services by individual providers. Three (43%) facilities had at least 3 FTEs on the ACT team.
- Services Provided in Community Settings. When asked "to what degree does your ACT program develop living skills in the community rather than in the office", five (72%) facilities indicated "All of the Time" or "Most of the Time". Only one facility said they develop living skills in the community "Not at All".

- Includes Clinical Component. Six out of seven of the facilities (86%) said that their ACT program provides substance abuse treatment services. Five (71%) provide psychiatric services, counseling/psychotherapy services, and housing support services. Four facilities (57%) reported that they provide employment rehabilitation services. A psychiatrist was a member of the ACT treatment team at five (71%) of the facilities, as were nurses and substance abuse specialists. A case manager was on the ACT team at six (86%) of the facilities. Three (43%) of the reporting facilities indicated that a vocational specialist or a peer support specialist was a member of their treatment team.
- Responsibility for Crisis Services. Six (86%) of the facilities indicated that their ACT teams had 24-hour responsibility for psychiatric emergencies.

Two of the seven facilities (29%) met DIG criteria for reporting ACT services by: 1) having a small caseload (ie. provider to client ratio of 1:10 or fewer); 2) providing services in the community rather than the office "Most of the Time" or "All of the Time"; 3) providing 24 hour crisis services; 4) including a clinical component, in addition to case management; AND 5) using a multidisciplinary team approach. For the two facilities that met DIG criteria, 14 consumers received ACT services in FY2005.

Supported Employment. Of the 13 facilities currently providing Supported Employment services, eight (62%) indicated that they measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Supported Employment were as follows:

- Competitive employment. Ten (77%) of the 13 facilities indicated that their employment specialists provide competitive job options in normalized settings where clients work side by side with employees hired from the general population "Most of the Time" or "All of the Time."
- Integration with Treatment. Ten (77%) of the facilities indicated that their employment specialists attend regular treatment meetings "Most of the

Time" or "All of the Time". Eleven (85%) of the 13 facilities reported that their employment specialists have frequent contact with treatment team members "Most of the Time" or "All of the Time."

- Rapid Job Search. Nine (69%) indicated that it typically takes 1-6 months before a consumer makes their first contact with an employer.
- Eligibility based on consumer choice (not client characteristics). Nine (69%) facilities indicated that no criteria are used to determine whether a person is eligible for supported employment services.

Seven (54%) of the 13 facilities met DIG criteria for reporting Supported Employment services by: 1) offering competitive job options; 2) being integrated with treatment; and 3) lacking inclusion criteria for eligibility. For the seven facilities that met DIG criteria, 704 consumers received Supported Employment services in FY2005.

Supported Housing. Of the 15 facilities currently providing Supported Housing services, three (23%) reported that they measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Supported Housing were as follows:

- Target Population. Thirteen (87%) facilities indicated that Supported Housing services are provided to persons who would not be in an independent living situation without this service, "All of the Time" or "Most of the Time".
- Staff Assigned. Twelve (80%) facilities indicated that specific staff are assigned to provide Supported Housing services.
- Housing is Integrated. Eleven (73%) of the facilities reported that Supported Housing consumers are living in integrated settings "All of the Time" or "Most of the Time".
- Consumer has right to Tenure. When asked to what extent the consumers in the Supported Housing programs have ownership or lease documents in their name, 11 (73%) of the respondents indicated "All of the Time" or "Most of the Time".

- Affordability. When asked what percentage of housing costs (rent and utilities) consumers typically pay for, 20 percent of the respondents indicated 0-20%, 47 percent indicated 21-39%, 27 percent indicated 40-59%, and 6 percent indicated 80% or more.

Five (33%) of the fifteen facilities met DIG inclusion criteria for reporting Supported Housing services by: 1) targeting persons who would not be in an independent living situation without this service; 2) having specific staff assigned to provide Supported Housing services; 3) providing integrated living situations; 4) offering consumers the right to tenure; and 5) offering affordable services. For the five facilities that met DIG criteria, 992 consumers received Supported Housing services in FY2005.

Family Psychoeducation. Of the 25 facilities that provide Family Psychoeducation, only two (8%) indicated that they currently measure Family Psychoeducation program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Family Psychoeducation were as follows:

- Structured Curriculum. Eight of the facilities (32%) provide Family Psychoeducation using a standard curriculum. Fifteen (60%) of the 25 facilities that provide Family Psychoeducation teach families problem solving skills "Most of the Time" or "All of the Time". When asked to what extent families are taught to identify early warning signs and symptoms of relapse, 18 (72 %) indicated "Most of the Time" or "All of the Time". Similarly, 18 (72%) indicated that families were taught to identify precipitating factors that may lead to a relapse "Most of the Time" or "All of the Time."

Eight of the facilities (32%) met DIG inclusion criteria for reporting Family Psychoeducation by providing this treatment using a standard curriculum. These eight facilities provided Family Psychoeducation services to 250 individuals in FY2005.

Integrated Treatment for Co-occurring Disorders. Of the 24 facilities that currently provide this EBP, 10 (42%) measure the fidelity of their Integrated Treatment for Co-occurring disorder programs (Figure 5). These nine facilities reported providing Integrated Treatment for Co-occurring Disorders to 2,800 individuals in FY2005.

Illness Management and Recovery (IMR). Of the 15 facilities that provide Illness Management and Recovery (IMR) services, four (27%) measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting IMR were as follows:

- Structured Curriculum. Seven (47%) facilities indicated that they provided Illness Management and Recovery services using a structured curriculum. Of the programs that did use a structured curriculum, all provided information about 'recovery strategies', 'practical facts about mental illness and treatment', 'effective use of medication', and ' coping with stress'.

Seven (47%) of the 15 facilities met DIG inclusion criteria for reporting IMR services by using a structured curriculum which includes information about mental illness facts, recovery strategies, using medications and stress management and coping. These seven facilities reported providing IMR services to 2,589 individuals in FY2005.

Medication Management. Of the 23 facilities that indicated they currently provide Medication Management, eight (33%) measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Medication Management were as follows:

- Treatment Plan Specifies Outcome for Each Medication. Fifteen (65%) facilities indicated that the Medication Management treatment plan specifies what outcome is expected for each outcome "Most of the Time" or "All of the Time."

- Desired Outcomes are Tracked Systematically. Fifteen facilities (65%) indicated that consumer responses to each medication are recorded using standardized forms and charts
- Sequencing of Anti-psychotic Medications are Based on Clinical Guidelines. Fifteen facilities (65%) also indicated that anti-psychotic medication changes were based on clinical guidelines "Most of the Time" or "All of the Time."

Eight (35%) of the 23 facilities met DIG inclusion criteria for reporting Medication Management services. These eight facilities reported providing Medication Management services to 9,132 individuals in FY2005.

Multisystemic Therapy (MST). Of the 13 facilities that reported providing MST services, 5 (39%) monitor program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting MST were as follows:

- Services are Provided by MST therapists or Masters level Professionals. Twelve (92%) indicated that MST services were provided by either MST therapists or Masters level professionals.
- Services are available 24/7. Six (46%) indicated that MST services were available 24/7.
- Services are Time-limited. Nine (69%) of the facilities indicated that their MST programs were time-limited.
- Services take into account the life situation and environment of the child. Ten (77%) of the MST programs provide parents with the resources needed for effective parenting "Most of the Time" or "All of the Time." Nine (69%) of the programs attempt to decrease youth involvement with delinquent and drug using peers "Most of the Time" or "All of the Time." Ten (77%) of the MST programs attempt to increase youth association with prosocial peers "Most of the Time" or "All of the Time."

Five (38%) of the facilities met DIG criteria for reporting MST services by 1) providing MST services with MST or Masters level therapists; 2) providing the services 24/7; 3) providing time limited services; and 4) taking into account the life situation of the child. These five facilities reported providing MST services to 103 children in FY2005.

Therapeutic Foster Care. Of the 10 facilities currently providing Therapeutic Foster Care, two (20%) indicated that they monitor program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Therapeutic Foster Care were as follows:

- A Program Is In Place to Train and Supervise Treatment Foster Parents. All of the Therapeutic Foster Care programs indicated that they provide training to foster parents "Most of the Time" or "All of the Time." Similarly, all said they provide ongoing supervision and support to the foster parents "Most of the Time" or "All of the Time".

Ten of the facilities (100%) met DIG criteria for reporting Therapeutic Foster Care services by providing training and supervision to Therapeutic Foster Care parents. These 10 facilities reported providing Therapeutic Foster Care services to 213 children in FY2005.

Functional Family Therapy (FFT). Of the nine facilities providing Functional Family Therapy, five (56 %) indicated that they monitor program fidelity (Figure 5).

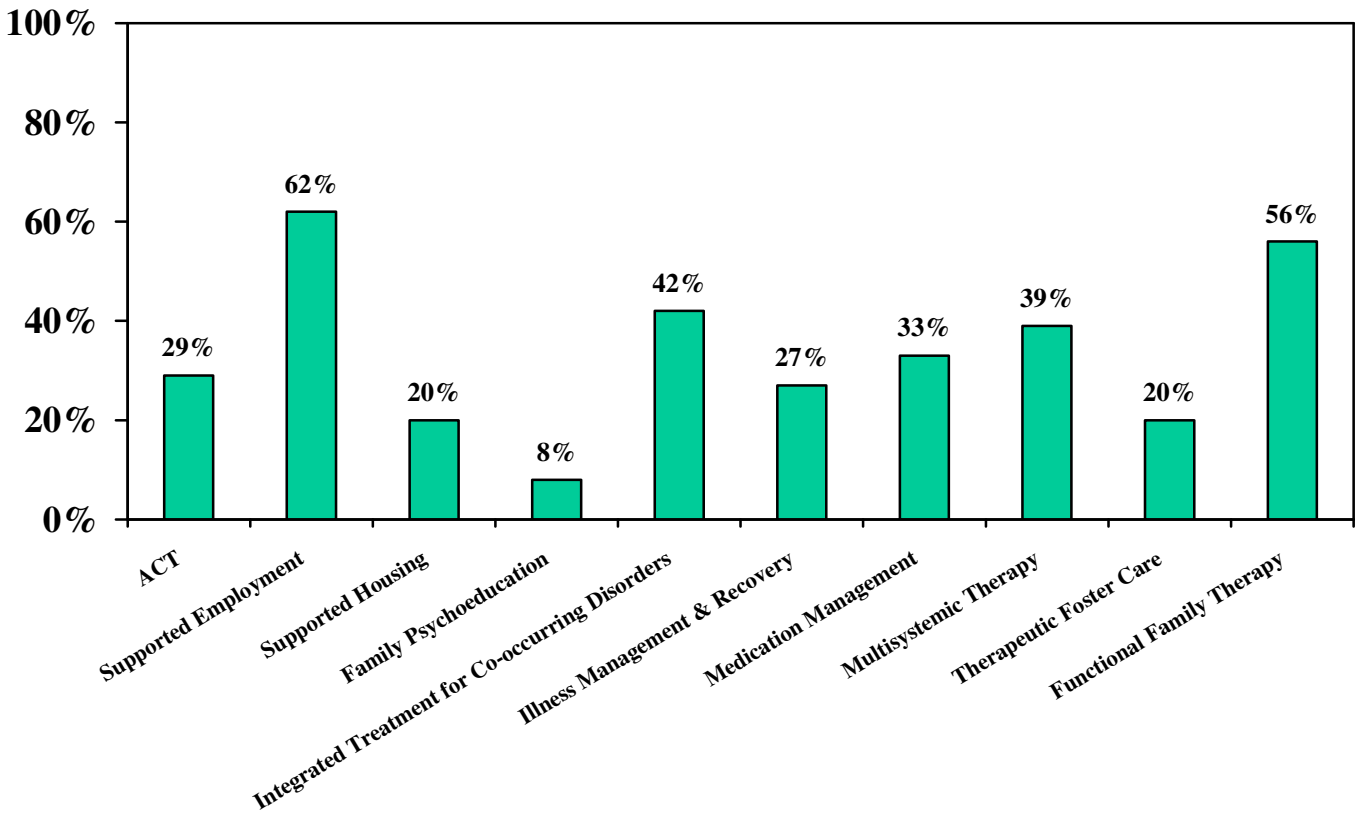
The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Functional Family Therapy were as follows:

- Services are Provided in Phases. When asked whether they provide Functional Family Therapy in phases related to engagement, motivation, assessment, behavior change, and generalization, eight (89%) of the facilities responded "Most of the Time" or "All of the Time".

- Flexible Delivery of Services Provided in Multiple Settings. All of the nine facilities indicated that they provide services at the client's home. The next most common location for providing services was in a clinic setting (67%).

Eight of the nine facilities (89%) met DIG criteria for reporting Functional Family Therapy services by: 1) providing services in phases and 2) providing services in multiple settings. These eight facilities reported providing FFT services to 357 children in FY2005.

Figure 5: Percent of Facilities Measuring Program Fidelity by EBP *



* Percentages are of those facilities that are currently providing EBPs.

D. Barriers to Implementing EBPs

Respondents were asked to identify barriers to implementing each EBP (see Table 2). For each EBP, the most frequently reported barrier was "Financial". The second most frequently reported barrier for seven of the 10 EBPs was "Shortage of appropriately trained workforce". The least frequently reported barrier to implementing EBPs was "Resistance by clinicians."

Table 2 also shows that barriers are specific to each EBP. For instance, for Supported Housing, the shortage of appropriately trained workforce is not nearly as critical as financial barriers. For other EBPs both are identified as critical (e.g., Integrated Treatment for Co-occurring Disorders).

Table 2: Barriers to EBP Implementation

	n	None	Financial	Modification of EBP model to fit local needs	Attaining and maintaining fidelity	Shortage of appropriately trained workforce	Resistance to implementing EBP by clinicians	Not Applicable
ACT	19	11%	90%	26%	21%	32%	0%	5%
Supported Employment	21	10%	67%	33%	24%	38%	0%	0%
Supported Housing	20	20%	80%	40%	30%	15%	0%	0%
Family Psychoeducation	37	16%	43%	38%	30%	35%	16%	3%
Integrated Treatment for Co-occurring Disorders	29	14%	69%	28%	17%	56%	10%	0%
Illness Management and Recovery	23	17%	52%	48%	35%	48%	9%	4%
Medication Management	34	27%	53%	24%	18%	41%	15%	3%
Multisystemic Therapy	22	9%	77%	50%	55%	50%	9%	5%
Therapeutic Foster Care	17	12%	82%	47%	24%	41%	0%	12%
Functional Family Therapy	20	10%	80%	35%	30%	50%	10%	5%

IV. DISCUSSION

This report describes an exploratory effort to assess the utilization of EBPs in Washington State. Data were collected from community inpatient and outpatient mental health facilities through the use of a survey. Sixty-seven of 150 eligible mental health facilities completed the survey, yielding a response rate of 45 percent.

Results showed that approximately three-fourths of the reporting facilities were providing at least one EBP, and more than half were providing more than one. Of the seven adult and three child EBPs examined, a greater proportion of the facilities were providing EBPs developed for adults than children (67% offer at least one EBP for adults; 35% offer at least one EBP for children). This is perhaps not surprising given that over twice as many adults are served by the mental health system than are children. The most frequently implemented adult EBP was Family Psychoeducation and the least frequently implemented adult EBP was Assertive Community Treatment (ACT). The most frequently implemented EBP for Children was Multisystemic Therapy. Among the reporting facilities, more people received Illness Management and Recovery (n=14,412) services in fiscal year 2005 (FY2005) than any other EBP EBPs designed for children were provided to 1,078 people by the surveyed facilities in FY2005.

With the exception of Supported Employment and Functional Family Therapy, less than 50 percent of the surveyed facilities monitor EBP program fidelity. Similarly, for the majority of EBPs, less than 50 percent of facilities met DIG inclusion criteria for reporting EBP services. This is potentially problematic since many studies have shown that greater adherence to EBP principle components (i.e., fidelity) result in better client outcomes (Becker, Xie, McHugo, Halliday, and Martinez, 2006; Gowdy, Carlson, & Rapp, 2003; McGrew, Bond, Dietzen, and Salyers, 1994). It appears that although most facilities are providing at least one EBP, in most cases it cannot be determined whether the EBPs are being implemented as described in the treatment literature.

Respondents believe that, regardless of which EBP was examined, the most frequent barrier to EBP implementation was financial, followed by a "shortage of an appropriately trained workforce." If facilities can overcome these barriers and further implement EBPs, future cost savings may be realized, if not for each facility, but for the mental health system in general. A recent meta-analytic review conducted by the Washington Institute for Public Policy (Aos, Mayfield, Miller & Wei Yen, 2006) found that not only do evidence based practices reduce the incidence and severity of serious mental illness, there are also significant savings per dollar of investment. They link these cost-benefits to fewer health care costs, reduced effects on the person's economic earnings in the job market, and lowered costs due to crime.

As with any project, results must be interpreted in light of procedural considerations and data limitations. The most critical limitation of the current project is potential sample bias. More specifically, less than 50 percent of the eligible sample responded to the survey. The low response rate is probably due to a variety of factors, not the least of which was the considerable time and effort required on the part of facility staff to complete the survey (e.g., contacting information systems staff to get the number of persons receiving each of the EBPs in FY2005). Moreover, we do not have information that allows us to determine the "representativeness" of the data that was collected. Hence, the relatively low response rate and lack of information to test representativeness calls into question whether the results can be generalized to Washington State mental health facilities as a whole.

In the future, methods of data collection for provider surveys should be changed to increase response rates. We recommend including MHD, and perhaps RSN-specific, letters of endorsement. In addition, information should be identified and collected that allows us to assess how representative the collected data are to the provider population in general.

Another limitation has to do with the relatively high percentage of "missing data" with some of the items. This was especially true of items that required a check "yes" if

affirmative and "no" if negative. Many of these items were simply left unchecked. The instrument needs to be revisited to eliminate or reduce the potential for missing data.

With the exception of Family Psychoeducation, less than 20 respondents answered the pilot questions for each EBP. The low response rate is partly due to the small number of facilities providing each EBP, but may also be related to the wording of individual questions (i.e., the respondent did not understand what a question was asking and therefore did not complete it). The pilot questions for each EBP need to be reconsidered.

Implications of the current study include: 1) educating policy makers and clinicians about the cost-effectiveness of EBPs and the importance of monitoring EBP fidelity, 2) investigating the factors responsible for successful EBP dissemination and implementation; and 3) exploring creative ways to combine resources from mental health, Medicaid, criminal justice, vocational rehabilitation, and other funding sources to support evidence-based services.

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Appendix A

Letters and Emails Sent to Providers

NOTIFICATION LETTER TO AGENCY ADMINSTRATORS

February 24, 2006

«Administrator»
«Agency»
«Streetaddress»
«City», «State» «Zipcode»

PROVIDER SURVEYS

As you know, there has been increased attention in the public mental health system on evidence-based practice (EBP) models and co-occurring mental and substance use disorders. In order to better understand these important issues, the Mental Health Division (MHD) has contracted with the Washington Institute to administer two web-based surveys.

The first survey focuses on the extent to which mental health facilities in Washington State utilize EBPs. Your answers will be used to fulfill MHDs federal requirements for reporting the number of children and adults who receive EBPs and will provide stakeholders with information about the barriers associated with adopting and implementing EBPs in Washington State. The purpose of the second survey is to better understand the work force capacity of mental health facilities in providing services to persons with co-occurring disorders. Information collected from this survey will be used to assist in planning for training and implementation of Senate Bill 5763.

REQUEST FOR CONTACT INFORMATION
Please provide us with contact information about the individual(s) whom is best suited to complete the 1) EBP survey, and 2) the Co-Occurring Disorders survey—if it is the same individual just report "Same." Although the Clinical Director of your facility might be best able to complete the surveys, any designee with extensive knowledge about EBP and/or co-occurring disorder programs at your facility would be appropriate. Once we receive this information we will contact them with next steps for completing the two surveys. RSN administrators have already been notified about the surveys.

Simply complete the table below and send the contact information to Bill Voss via telephone (253-761-7594), FAX (253-756-3987) or e-mail, bvoss15@u.washington.edu by March 8, 2006.

SURVEY	CONTACT PERSON	PHONE	E-MAIL
Evidence-Based Practices			
Co-Occurring Disorders			

Thank you for your assistance. We look forward to working with you on these exciting projects.

William D. Voss, PhD
Research Associate
University of Washington, Department of Psychiatry and Behavioral Sciences
Washington Institute for Mental Illness: Research and Training (WIMIRT), Western Branch

PRE-NOTIFICATION E-MAIL TO AGENCY CONTACT PERSON

Dear Colleague,

In the next couple days you will receive an email requesting that you fill out a web-based survey for an important research project being conducted by the Washington Institute for Mental Illness: Research and Training (WIMIRT).

The survey concerns the utilization of evidence-based practices (EBPs) in Washington State.

We are writing to you in advance because we have found that people often like to know ahead of time that they will be contacted. This study is an important one and will be used to meet federal reporting requirements regarding the use of EBPs as well as identify barriers to EBP adoption and implementation in Washington State.

Thank you for your time. It is only with the generous help from people like you that our system can continue to improve.

Sincerely,

William D. Voss, Ph.D.
Research Associate
Washington Institute for Mental Illness: Research and Training (WIMIRT)
(253) 761-7594

COVER LETTER/NOTIFICATION E-MAIL

Dear Colleague,

I am writing to ask for your help in completing a survey concerning the extent to which evidence-based practices (EBP) are being utilized in Washington State.

Information obtained from the survey will be used to fulfill the Mental Health Division's federal requirements for reporting the number of children and adults who receive EBPs and will provide stakeholders with information about the barriers associated with adopting and implementing EBPs in Washington State.

There are three ways to answer this survey:

1. Enter the data online:
   - First, go to the Washington Institute's website at http://depts.washington.edu/washinst/.
   - From the Washington Institute's main web page, left-click with your mouse on **"EVIDENCE-BASED PRACTICES" (EBP)** survey.
   - The last step is to enter your facility's custom ID number, which is: **###**

2. Print out a copy of the survey (see attached Word document) and return it with your answers to:

   Bill Voss
   The Washington Institute for Mental Illness Research and Training (WIMIRT)
   9601 Steilacoom Blvd., S.W.
   Tacoma, WA 98498-7213

3. Fill out a copy of the survey and send it as an email attachment to: bvoss15@u.washington.edu

Please complete the survey by April 28th, 2006. If you have difficulties submitting data or have any questions or comments related to this survey, please contact the survey administrator: Bill Voss, phone: 253-761-7594, email: bvoss15@u.washington.edu.

Thank you for your time and effort. If you have any questions or comments, please do not hesitate to contact me.

Sincerely,

Bill Voss, Ph.D.
Research Associate
University of Washington, Department of Psychiatry and Behavioral Sciences
The Washington Institute for Mental Illness: Research and Training (WIMIRT)

THANK YOU/REMINDER EMAIL

Dear Colleague,

A couple weeks ago I sent out an email inviting you to participate in a survey regarding the use of evidence based practices (EBPs).

If you have already completed the survey, I want to thank you for participating. If you have not completed the survey, please do so as soon as possible. There are three ways you can respond to this survey:

1. Print out a copy of the survey (see attached Word document) and return it with your answers to:

    Bill Voss
    The Washington Institute for Mental Illness Research and Training (WIMIRT)
    9601 Steilacoom Blvd., S.W.
    Tacoma, WA 98498-7213

2. Fill out a copy of the survey (see attached Word document) and send it as an email attachment to: bvoss15@u.washington.edu.

3. Enter the data online:
   - First, go to the Washington Institute's website at http://depts.washington.edu/washinst/.
   - From the Washington Institute's main web page, left-click with your mouse on **"EVIDENCE-BASED PRACTICES" (EBP)** survey.
   - The last step is to enter your facility's custom ID number, which is: ###.

Should you have any questions or concerns, feel free to contact me (Bill Voss) at (253) 761-7594. Thank you for your cooperation.

Bill Voss

Appendix B

The Survey Instrument

Evidence-Based Practices in Washington State:
Survey of Mental Health Providers

INTRODUCTION:

Purpose: The purpose of this survey is to provide the Mental Health Division (MHD) and other stakeholders with information about the extent to which evidence-based practices (EBPs) are being used in Washington State. Survey results will also be used to identify barriers to implementing EBPs and to track our progress now and in the future.

Adult Evidence-Based Practice Definitions

The following definitions for evidence-based-practices are taken from SAMHSA's Data Infrastructure Grants: Guidelines for Reporting Evidence-Based Practices.

Assertive Community Treatment (ACT): A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings.

Supported Employment: Mental Health Supported Employment (SE) is an evidence-based service for persons with serious mental illness to promote rehabilitation and help them return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Supported Housing: Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported

housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.

Family Psycho-education: Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family Psycho-Education programs may be either multi-family or single-family focused. Core characteristics of family Psycho-Education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

Integrated Treatment for Co-occurring Disorders (Mental Health/Substance Abuse): Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Illness Management/Recovery: Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with a mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and rehospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

Medication Management: In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

Children and Adolescent Evidence-Based Practice Definitions:

Multi-systemic Therapy (MST): Multi-systemic Therapy (MST) is an intensive family- and

community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multi-systemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

Therapeutic Foster Care: Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

Functional Family Therapy: Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

1. Are you currently providing or planning to provide any of the following evidence based practices, as defined above, for adults? *(Please check all relevant cells)*

Evidence-Based Practice: *(see definitions above)*	Services Currently Available	**Not now available but plan to provide in the future**	Not available and have no plans to provide in the future
a. Assertive Community Treatment			
b. Supported Employment			
c. Supported Housing			
d. Family Psycho-education			
e. Integrated Treatment for Co-occurring disorders (MH/SA)			
f. Illness Management and Recovery			
g. Medication Management			
h. Other _____			

2. Are you currently providing or planning to provide any of the following evidence based practices, as defined above, for children/adolescents? *(Please check all relevant cells)*

Evidence-Based Practice:	***Services currently available***	***Not now available but planning to provide in the future***	***Not available and have no plans to provide in the future***
a.Multisystemic Therapy (Conduct Disorder)			
b. Therapeutic Foster Care			
c. Functional Family Therapy			
d. Other: _____			

If your agency or facility currently provides one or more EBPs, please answer question 3.

If your agency does not provide ANY EBP, please skip to question 8.

3. Does your agency or facility have the capacity to report the number of consumers who received the following EBPs?

Evidence-Based Practice: *(see definitions above)*	***Yes***	**No**	***Not applicable, we do not provide this EBP***
a. Assertive Community Treatment			
b. Supported Employment			
c. Supported Housing			
d. Family Psycho-education			
e. Integrated Treatment for Co-occurring disorders (MH/SA)			
f. Illness Management and Recovery			
g. Medication Management			
h. Multisystemic Therapy			
i. Therapeutic Foster Care			

j. Functional Family Therapy			

Please complete the following question only if your agency is providing any of the evidence based practices listed in the previous section.

Note: If your agency does not have the capacity to report this information, please skip to question 5.

4. If you are currently providing any of the evidence-based practices listed above, please provide the total number of persons served for each EBP in FY 2005 (July 1, 2004 – June 30, 2005)

	Number of Persons Served (FY 2005)
a. Assertive Community Treatment	
b. Supported Employment	
c. Supported Housing	
d. Family Psycho-education	
e. Integrated Treatment for Co-occurring Disorders (MH/SA)	
f. Illness management/recovery	
g. Medication Management	
h. Multi-systemic Therapy	
i. Therapeutic Foster Care	
j. Functional Family Therapy	
k. Other: _____	
l. Other: _____	

5. In this question, we are interested in whether your program assesses or monitors fidelity (i.e., a measure of how closely treatment is adhering to established standards).

For the evidence-based practices listed below, please select "Yes", "No" or "Not Applicable" for each item. Click "Yes" <u>only</u> if you measure or monitor fidelity according to some identified measure or practice standard, "No" if you provide the EBP service but do not monitor it, and "Not Applicable" if you do not provide that EBP service:

	Assess/Monitor Fidelity of program		
	Yes	No	**Not Applicable**

a. Assertive Community Treatment	☐	☐	☐
b. Supported Employment	☐	☐	☐
c. Supported Housing	☐	☐	☐
d. Family Psycho-education	☐	☐	☐
e. Integrated Treatment for Co-occurring Disorders (MH/SA)	☐	☐	☐
f. Illness management and recovery	☐	☐	☐
g. Medication management	☐	☐	☐
h. Multi-systemic Therapy	☐	☐	☐
i. Therapeutic Foster Care	☐	☐	☐
j. Functional Family therapy	☐	☐	☐
k. Other: _____	☐	☐	☐
l. Other: _____	☐	☐	☐
m. Other: _____	☐	☐	☐

6. Is training provided to your staff for the provision of evidenced-based services?

☐ Yes (if yes, continue to question 7)
☐ No (if no, skip to question 8).

7. What mechanisms are used to provide training to staff related to these evidence-based services? (Please check all that apply)

	NONE	Internal Staff	Collaboration with Universities	*Provider-to-provider training*	*Expert Consultants*	*Outside Accreditation* (specify)	*NOT APPLICABLE* (Don't Provide EBP)
a. Assertive Community Treatment							
b. Supported Employment							
c. Supported Housing							
d. Family Psycho-education							
e. Integrated Treatment for Co-occurring Disorders (MH/SA)							
f. Illness management/recovery							
g. Medication Management							
h. Multi-systemic Therapy							
i. Therapeutic Foster Care							
j. Functional Family Therapy							
k. Other: _____							

Next, we are concerned about the barriers that you may be experiencing in providing evidenced based services.

8. In the table below, identify any barriers that you are encountering for each of the EBP's: (please select all that apply)

	None	Shortages of appropriately trained workforce	Financing Issues in paying for EBP	Modification of the EBP model to meet local needs	**Attaining or Maintaining Fidelity to EBP model standards**	Resistance to implementing EBP from clinicians	Not Applicable
a. Assertive Community Treatment							
b. Supported Employment							
c. Supported Housing							
d. Family Psycho-education							
e. Integrated Treatment for Co-occurring Disorders (MI/SA)							
f. Illness management/recovery							
g. Medication Management							
h. Multi-systemic Therapy							
i. Therapeutic Foster Care							
j. Functional Family Therapy							
k. Other: _____							
l. Other: _____							

Assertive Community Treatment (ACT)

The next series of questions asks about assertive community treatment (ACT). If your agency or facility provides ACT services, please answer the following questions. If your agency DOES NOT provide ACT services, please skip to question 16.

9. Our ACT program emphasizes a team approach rather than an approach that emphasizes services by individual providers.
   - ☐ Not at all
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time
   - ☐ Don't know

10. To what degree does your ACT program develop community living skills in the community rather than in the office.
   - ☐ Not at all
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time
   - ☐ Don't Know

11. Which of the following services are provided by your ACT team:
   - ☐ psychiatric services
   - ☐ counseling/psychotherapy
   - ☐ housing support
   - ☐ substance abuse treatment
   - ☐ employment/rehabilitative services

12. Which of the following staff currently work on your ACT team (check all that apply)?
   - ☐ Psychiatrist
   - ☐ Nurse
   - ☐ Substance Abuse specialist
   - ☐ Vocational specialist
   - ☐ Psychologist
   - ☐ Case manager
   - ☐ Social Worker
   - ☐ Peer Support Specialist
   - ☐ Other: _____

13. Does your ACT program have 24-hour responsibility for covering psychiatric crises of consumers who are receiving ACT services?
   - ☐ Yes

☐ No

14. What is the average Staff to Client Ratio of your ACT team?

_____ Patients per ACT Team staff member.

15. How many full time staff are on your ACT team (s)?

_____ FTE

Supported employment

If your agency/facility provides supported employment, please answer the following questions. If your agency/facility does not provide supported employment services, please skip to question 20.

16a. Our employment specialists provide competitive job options in normalized settings where clients work side-by-side with employees hired from the general population.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

16b. Our employment specialists provide job options in a variety of industries (i.e., clerical, technical, food service, etc).

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

17a. Our employment specialists attend regular treatment team meetings.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ ***Don't Know***

17b. Our employment specialists have frequent contact with treatment team members.

☐ Not at all
☐ Some of the time
☐ Most of the time

☐ All of the time
☐ ***Don't Know***

18. What is the typical length of time between when a person begins the supported employment program and their first contact with an employer?

☐ Within 1 month
☐ 1-6 months
☐ 7-9 months
☐ 10-12 months
☐ More than a year

19. What criteria, if any, are used to determine if a person is eligible for vocational services? **(check all that apply)**

☐ Job readiness
☐ Lack of substance abuse
☐ No history of violent behavior
☐ Mild psychiatric symptoms
☐ No criteria are used, all adult clients with severe mental disorders are eligible

Supported Housing

If your agency/facility provides supported housing services, please answer the following questions. *If your agency/facility does not provide supported housing services, please skip to question 25.*

20. Are specific staff assigned to provide supported housing services at your agency?

☐ Yes
☐ No

21. To what extent is your supported housing program provided to persons who would not have a viable housing arrangement without this service?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

22.To what extent are supported housing consumers living in facilities that are integrated (i.e., the consumer is living with or around people who do not have a mental disorder):

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

23. To what extent do consumers have the ownership or lease documents of the house, apartment, or similar setting in their name?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

24.What percentage of housing costs (rent and utilities) do consumers typically pay for?

- ☐ 0 – 20%
- ☐ 21% - 39%
- ☐ 40% - 59%
- ☐ 60% - 79%
- ☐ 80% or more

Family Psycho-education

If your agency/facility provides Family Psycho-education, please answer the following questions. *If your agency/facility does not provide Family Psycho-education, please skip to question 30.*

25. Do you provide family psycho-education using a structured curriculum?

- ☐ No
- ☐ Yes

26. (If you answered yes to question 25, which topics are typically included in your psycho-educational program? (check all that apply)

- ☐ Psychobiology of mental illness
- ☐ Diagnosis and treatment
- ☐ Family reaction to mental illness and its stages
- ☐ Psychosis as a family trauma
- ☐ Relapse prevention
- ☐ Family guidelines
- ☐ Recovery
- ☐ None of the above

27. To what extent are families taught problem solving skills?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

28. To what extent are families taught to identify early warning signs and symptoms of relapse?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

29. To what extent are families taught to identify precipitating factors that may lead to a relapse?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

Illness Management/Recovery

If your agency provides Illness Management/Recovery, please answer the following questions. If your agency does not provide Illness Management/Recovery services, please skip to question 32.

30. Do you provide Illness Management and Recovery (IMR) services using a structured curriculum?

- ☐ Yes
- ☐ No

31. (If yes) Which topics are typically included in the IMR curriculum? (check all that apply)

- ☐ Recovery strategies
- ☐ Practical facts about mental illness and treatment
- ☐ The stress-vulnerability model
- ☐ Building social support
- ☐ Effective use of medication
- ☐ Reducing relapse
- ☐ Coping with stress
- ☐ Coping with symptoms
- ☐ Enhancing wellness
- ☐ Other:_____

Medication Management

If your agency provides the evidence-based practice called "Medication Management", please answer the following questions. If your agency does not provide medication management services, please skip to question 36.

32. To what degree does the treatment plan specify what outcome is expected for each medication?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

33. Are consumer responses to each medication recorded using standardized forms and charts?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

34. Are medication errors identified and tracked using standardized forms and charts?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

35a. Are anti-psychotic medication changes based on clinical guidelines?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

35b. To what extent do consumers and practitioners share in the decision making about medication management?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

Multi-systemic Therapy (MST)

If your agency provides Multi-systemic Therapy, please answer the following questions. (If your agency does not provide Multi-systemic Therapy services, please skip to question 42.

36. Are MST services provided by either MST therapists or Masters level professionals?

- ☐ No
- ☐ Yes

37. Are MST services available 24/7?

- ☐ No
- ☐ Yes

38. Are MST services time-limited?

- ☐ No
- ☐ Yes

39. Our MST program provides parent(s) with the resources needed for effective parenting.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ **Don't Know**

40. Our MST program attempts to decrease youth involvement with delinquent and drug using peers.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

41.Our MST program attempts to increase youth association with prosocial peers.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

Therapeutic Foster Care

If your agency provides Therapeutic Foster Care, please answer the following questions. (If your agency does not provide therapeutic foster care services, please skip to question 44.

42. Do foster parents receive training to work with children with emotional and behavioral disorders?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

43. Do foster parents receive ongoing supervision and support?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

Functional Family Therapy

If your agency provides Functional Family Therapy, please answer the following questions. (If your agency does not provide functional family therapy services, please skip to question 47.

44. Our functional family therapy program services are provided in phases related to engagement, motivation, assessment, behavior change, and generalization.
☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

45. On average, how many hours of direct service are children and their families provided?

_____

46. Functional Family Therapy is provided in (please check all that apply):

☐ Home
☐ Clinic
☐ Juvenile court
☐ School
☐ ***Other community setting***

Other EBPs and Best or Promising Practices:

47. Does your agency/facility provide any other emerging evidence-based practices or other promising practices (practices for which the research evidence base is still being finalized, but that appear to be very promising practices; examples may include consumer run services, etc.)?

☐ Yes
☐ No

48. If you answered Yes to question #47, please list those Emerging EBPs and other Innovative Practices provided by your agency/facility.

Emerging EBPs and Innovative Practices:
1.
2.
3.
4.
5.

CLINICAL PRACTICE GUIDELINES

In recent years, several clinical practice guidelines and/or treatment recommendations have been developed by several groups. These practice guidelines are based on research results regarding the effectiveness or efficacy of particular treatments or medications. This section of the survey gathers information regarding the use of any of the published treatment guidelines as either an official policy of your agency or as part of common, typical practice patterns.

49. Is your agency using standardized clinical guidelines and treatment recommendations?

☐ Yes
☐ No

50. If you answered yes to question 49, which of the following clinical guidelines and recommendations are being used? *(please check all that apply)*

☐ American Psychiatric Association
☐ Consensus "Tri-University" Project
☐ Schizophrenia Patient Outcome Research Team (PORT)
☐ Texas Medication Algorithm Project (TMAP)
☐ American Psychological Association
☐ Other (specify)_____
☐ Other (specify)_____

51. Have any of the clinical guidelines been selected/adopted as an official agency policy for the treatment of persons with particular mental disorders?

☐ Yes
☐ No

52. If yes, for which conditions or diagnostic groups are clinical guidelines being used?
(Please check all that apply)

☐ Mood disorders
☐ Major unipolar depression

- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Other psychotic disorder (specify): _____
- ☐ Dementia
- ☐ Alcohol abuse and dependence
- ☐ Other substance abuse and dependence
- ☐ Dual disorders (mental and addictive)
- ☐ Anxiety disorders
- ☐ Other (specify):_____

53. What is your position title in the agency/facility you work in?

_____

54. What is the name of the agency/facility you work for?

_____

Thank you for taking this survey. We appreciate your participation.

Appendix C

Responses to Individual Fidelity Questions

Table 3: Assertive Community Treatment Pilot Questions, n = 7

Item	n	%
emphasizes a team approach rather than an approach that emphasizes services by individual providers.		
Not at All……..	0	0
Some of the Time……..	0	0
Most of the Time…….	1	14

All of the Time……	5	71
Don't Know……..	0	0
Missing……	1	14
To what degree does your ACT program develop community living skills in the <u>community</u> rather than in the office.		
Not at All……..	1	14
Some of the Time……...	0	0
Most of the Time……	3	43
All of the Time……	2	29
Don't Know……..	0	0
Missing……	1	14
Which of the following services are provided by your ACT team:		
Psychiatric services……	5	71
Counseling/psychotherapy……..	5	71
Housing support……	5	71
Substance abuse treatment……..	6	86
Employment/rehabilitative services……..	4	57
Missing……	1	14
<u>Which of the following staff currently work on your ACT team (check all that apply)?</u>		
Psychiatrist……...	5	71
Nurse……	5	71
Substance Abuse specialist……..	5	71
Vocational specialist……..	3	43
Psychologist……	1	14
Case manager……	6	86
Social Worker……..	2	29
Peer Support Specialist……	1	14
Missing……..	1	14
Do you provide 12 hour responsibility for the clients on your ACT team?		
Yes……	5	86
No……	0	0
Missing……	1	14
<u>What is the average Staff to Client Ratio of your ACT team?</u>		
<u>1:4……...</u>	2	29
<u>1:10……</u>	2	29
<u>1:12……</u>	1	14
<u>1:15……</u>	1	14
<u>Missing……...</u>	1	14

Table 4: Supported Employment Pilot Questions, n = 13

Item	n	%
Our employment specialists provide competitive job options in normalized settings where clients work side-by-side with employees hired from the general population.		
Not at All……	0	0
Some of the Time……	2	15
Most of the Time……..	3	23
All of the Time……..	7	54
Don't Know……...	0	0
	1	8
Missing……..		
Our employment specialists provide job options in a variety of industries (i.e., clerical, technical, food service, etc).		
Not at All……	0	0
Some of the Time……	3	23
Most of the Time…….	1	8
All of the Time……..	8	62
Don't Know……...	0	0
	1	8
Missing…….		
Our employment specialists attend regular treatment team meetings.		
Not at All……		
Some of the Time……	0	0
Most of the Time……..	2	15
All of the Time……..	3	23
Don't Know……...	7	54
	0	0
Missing…….	1	8
Our employment specialists have frequent contact with treatment team members.		
Not at All……	0	0
Some of the Time……	1	8
Most of the Time……..	3	23
All of the Time……..	8	62
Don't Know……...	0	0
	1	8
Missing…….		
What is the typical length of time between when a person begins the supported employment program and their first contact with an employer?		
Within 1 month……	0	0
1-6 months……	9	69
7-9 months……	3	23
10-12 months……	0	0
More than a year……..	0	0

Missing……..	**1**	**8**
What criteria, if any, are used to determine if a person is eligible for vocational services? (check all that apply)		
Job readiness……	**3**	**23**
Lack of substance abuse……..	**2**	**15**
No history of violent behavior……..	**2**	**15**
Mild psychiatric symptoms……	**1**	**8**
No criteria are used, all adult clients with severe mental disorders are eligible……..	**9**	**69**
Missing……	**2**	**15**

Table 5: Supported Housing Pilot Questions, n = 15

Item	n	%
Are specific staff assigned to provide supported housing services at your agency?		
Yes…….....	**12**	**80**
No…….	**3**	**20**
Missing……..	**0**	**0**
To what extent is your supported housing program provided to persons who would not have a viable housing arrangement without this service?		
Not at All.....	**0**	**0**
Some of the Time.....	**2**	**13**
Most of the Time.....	**7**	**47**
All of the Time.....	**6**	**40**
Don't Know.....	**0**	**0**
	0	**0**
Missing…….		
To what extent are supported housing consumers living in facilities that are integrated (i.e., the consumer is living with or around people who do not have a mental disorder):		
Not at All.....	**2**	**13**
Some of the Time.....	**2**	**13**
Most of the Time.....	**7**	**47**
All of the Time.....	**4**	**27**
Don't Know.....	**0**	**0**
	0	**0**
Missing…….		
To what extent do consumers have the ownership or lease documents of the house, apartment, or similar setting in their name?		
Not at All.....	**2**	**13**
Some of the Time.....	**2**	**13**

Most of the Time.....	7	47
All of the Time.....	4	27
Don't Know.....	0	0
	0	0
Missing……..		
What percentage of housing costs (rent and utilities) do consumers typically pay for?		
0 – 20%.....	3	20
21% - 39%.....	7	47
40% - 59%.....	4	27
60% - 79%.....	0	0
80% or more……..	1	7
	0	0
Missing…….		

Table 6: Family Psychoeducation Pilot Questions, n = 25

Item	n	%
Do you provide family psycho-education using a structured curriculum?		
Yes……	8	32
No……..	15	60
Missing……..	2	8
If you answered yes to question 25, which topics are typically included in your psycho-educational program? (check all that apply)		
Psychobiology of mental illness……	4	16
Diagnosis and treatment……	7	28
Family reaction to mental illness and its stages…….	8	32
Psychosis as a family trauma……	2	22
Relapse prevention……	4	16
Family guidelines…….	8	32
Recovery……...	4	16
None of the above……...	0	0
Missing……..	16	64
) what extent are families taught problem solving skills?		
Not at All……	0	0
Some of the Time……	8	32
Most of the Time……..	9	36
All of the Time……..	6	24
Don't Know……...	0	0
	2	8
Missing…….		
To what extent are families taught to identify early warning signs		

and symptoms of relapse?		
Not at All……	**0**	**0**
Some of the Time……	**4**	**16**
Most of the Time……..	**12**	**48**
All of the Time……..	**6**	**24**
Don't Know……...	**0**	**0**
	3	**12**
Missing……..		
To what extent are families taught to identify precipitating factors that may lead to a relapse?		
Not at All……	**0**	**0**
Some of the Time……	**5**	**20**
Most of the Time……..	**12**	**48**
All of the Time……..	**6**	**24**
Don't Know……...	**0**	**0**
	2	**8**
Missing……..		

Table 7: Illness Management and Recovery Pilot Questions, n = 15

Item	n	%
Do you provide Illness Management and Recovery (IMR) services using a structured curriculum?		
Yes……	**7**	**47**
No……..	**6**	**40**
Missing……..	**2**	**13**
(If yes) Which topics are typically included in the IMR curriculum? (check all that apply)		
Recovery strategies……	8	**53**
Practical facts about mental illness and treatment……	8	**53**
The stress-vulnerability model……...	6	**40**
Building social support……	8	**53**
Effective use of medication……	8	**53**
Reducing relapse……	8	**53**
Coping with stress……	8	**53**
Coping with symptoms……	8	**53**
Enhancing wellness……	8	**53**
Other……..	7	**53**
Missing……..	2	**13**
	7	**7**

Table 8: Medication Management Pilot Questions, n = 23

Item	n	%
what degree does the treatment plan specify what outcome is expected for each medication?		

Not at All……	2	9
Some of the Time……	6	26
Most of the Time……..	5	22
All of the Time……..	10	44
Don't Know……...	0	0
Missing…….	0	0
Are consumer responses to each medication recorded using standardized forms and charts?		
Not at All……	3	13
Some of the Time……	2	9
Most of the Time……..	4	17
All of the Time……..	11	48
Don't Know……...	2	9
Missing…….	1	4
Are medication errors identified and tracked using standardized forms and charts?		
Not at All……	2	9
Some of the Time……	1	4
Most of the Time……..	2	9
All of the Time……..	12	52
Don't Know……...	3	13
Missing…….	3	13
Are anti-psychotic medication changes based on clinical guidelines?		
Not at all……	0	0
Some of the time…….	0	0
Most of the time……	4	17
All of the time……	11	48
Don't Know……...	5	22
Missing……..	3	13
To what extent do consumers and practitioners share in the decision making about medication management?		
Not at all……	0	0
Some of the time…….	0	0
Most of the time……	9	39
All of the time……	11	48
Don't Know……...	0	0
Missing……..	3	13

Table 9: Multisystemic Therapy Items, n = 13

Item	n	%

Are MST services provided by either MST therapists or Masters level professionals?		
Yes……		
No…….	12	92
Missing…….	0	0
	1	8
Are MST services available 24/7?		
Yes……	6	46
No…….	6	46
Missing…….	1	8
Are MST services time-limited?		
Yes……	9	69
No…….	3	23
Missing…….	1	8
ur MST program provides parent(s) with the resources needed for effective parenting.		
Not at All……	0	0
Some of the Time……	2	15
Most of the Time……..	5	39
All of the Time……..	5	39
Don't Know……...	0	0
	1	8
Missing……..		
Our MST program attempts to decrease youth involvement with delinquent and drug using peers.		
Not at All……	0	0
Some of the Time……	1	8
Most of the Time……..	1	8
All of the Time……..	8	62
Don't Know……...	2	15
	1	8
Missing……..		
Our MST program attempts to increase youth association with prosocial peers.		
Not at All……	0	0
Some of the Time……	0	0
Most of the Time……..	3	23
All of the Time……..	7	54
Don't Know……...	2	15
Missing……..	1	8

Table 10: Therapeutic Foster Care Pilot Questions, n = 10

Item	n	%
Do foster parents receive training to work with children with		

emotional and behavioral disorders?		
Not at all……..	**0**	**0**
Some of the time……...	**0**	**0**
Most of the time…….	**1**	**10**
All of the time…….	**9**	**90**
Don't Know…….	**0**	**0**
Missing……	**0**	**0**
Do foster parents receive ongoing supervision and support?		
Not at all……..	0	**0**
Some of the time……...	0	**0**
Most of the time……..	1	**10**
All of the time…….	9	**90**
Don't Know…….	0	**0**
Missing……	0	**0**

Table 11: Functional Family Therapy, n = 9

Item	n	%
Our functional family therapy program services are provided in phases related to engagement, motivation, assessment, behavior change, and generalization.		
Not at all……..	**0**	**0**
Some of the time……...	**1**	**11**
Most of the time…….	**2**	**22**
All of the time…….	**6**	**67**
Don't Know…….	**0**	**0**
Missing……	**0**	**0**
On average, how many hours of direct service are children and their families provided? _____		
0-25 hours……..	4	**44**
26-50 hours……	3	**33**
>50 hours……	1	**11**
Missing……	1	**11**
Functional Family Therapy is provided in (please check all that apply):		
Home……	9	**100**
Clinic…….	6	**67**
Juvenile court……..	3	**33**
School……..	5	**56**
Other community setting……...	5	**56**